ATLANTIC HEALTH SYSTEM

Medicare Secondary Payor Questionnaire

Please print:

ACCOUNT #: ______________________

PATIENT NAME: ______________________

DATE(S)-OF-SERVICE: ______________________

MSP Questionnaire PART I

Is the patient receiving Black Lung Benefits? ☐Yes ☐No Date Began: ______________
{If Yes, Black Lung is primary only for claims related to Black Lung.}

Are the services covered by a government program such as a research grant? ☐Yes ☐No

Has the Department of Veteran's Affairs authorized and agreed to pay for care at this facility? ☐Yes ☐No
{If Yes, DVA is primary for these services.}

Is the illness or Injury due to a work related accident / condition? ☐Yes ☐No Date: ______________
{If Yes, Worker's Compensation is primary only for claims related to work related injuries or illness.}
Worker's Compensation Policy: ______________________

MSP Questionnaire PART II

Is the illness / Injury due to a non-work related accident? ☐Yes ☐No Accident Date: ______________

Did an auto accident cause the illness/injury? ☐Yes ☐No
{If Yes, no-fault insurer is primary only for claims related to the accident.}

No Fault/Liability Insurance: ______________________ Claim # ______________

Was another party responsible for the accident? ☐Yes ☐No
{If Yes, liability insurer is primary for claims related to the accident.}
Liability Insurance: ______________________ Claim # ______________

MSP Questionnaire PART III

Are you entitled to Medicare based on: ☐AGE ☐ESRD ☐DISABILITY
{If AGE please complete part IV, If Disability please complete part V, If ESRD please complete part VI}

MSP Questionnaire PART IV - AGE

Is the patient currently employed? ☐Yes ☐No Retirement Date: ______________
Employer Name, Address & telephone #

____

Is the spouse currently employed? ☐Yes ☐No Retirement Date: ______________
Spouse's Employer Name, Address & telephone #

____

If the patient answered No to both questions, Medicare is primary unless the patient answered Yes to questions in Part II or I. ***(DO NOT PROCEED)***

Does the patient have Group Health Insurance coverage based on his / spouse's current employment? ☐Yes ☐No
{If No, Medicare is primary payor unless the patient answered Yes to the questions in Part I or II.}

Does the employer that sponsors the Group Health Insurance employ 20 or more employees? ☐Yes ☐No
{If Yes, Group Health Insurance is primary. Obtain information below. > If No, Medicare is primary unless the patient answered Yes to the questions in Part I or II.}
Group Health Plan name, Address & telephone #:

____

Policy #: ______________________ Group #: ______________________

Policy Holder: ______________________ Relationship: ______________________

MSP Questionnaire PART V - DISABILITY

Is the patient currently employed? ☐Yes ☐No Retirement Date: ______
Employer Name, Address & telephone #

Is the family member currently employed? ☐Yes ☐No Retirement Date: ______
Employer Name, Address & telephone #

If the patient answered No to both questions, Medicare is primary unless the patient answered Yes to questions in Part I or II. > (DO NOT PROCEED)

Does the patient have GHP coverage based on his own or a family member's current employment? ☐Yes ☐No
{If No, Medicare is primary payor unless the patient answered Yes to the questions in Part I or II.}

Does the employer that sponsors the Group Health Plan employ 100 or more employees? ☐Yes ☐No
{If Yes, Group Health Plan is primary. Obtain the following information. If No, Medicare is primary unless the patient answered Yes to questions in Part I or II.}
Group Health Plan name, Address & telephone #:

Policy #: ______ Group #: ______
Policy Holder: ______ Relationship: ______

MSP Questionnaire PART VI – ESRD

Does the patient have Group Health Plan coverage based on his own or a family member's current employer?
☐Yes ☐No *{If No, Medicare is primary. If Yes, Group Health Plan is primary. Obtain the following information.}*
Group Health Plan name, Address & telephone #:

Policy #: ______ Group #: ______
Policy Holder: ______ Relationship: ______

Has the patient received a kidney transplant? ☐Yes ☐No Transplant Date: ______
Has the patient received Dialysis? ☐Yes ☐No Date Started: ______
Date Self Dialysis Training Program Started: ______

Is the patient within the 30 month coordination Period? ☐Yes ☐No
{If No, Medicare is primary.}

Is the patient entitled to Medicare based on ESRD & age or ESRD & disability? ☐Yes ☐No
{If No, Group Health Plan is primary during the 30-month coordination period.}

Was the patient's initial entitlement to Medicare based on ESRD? ☐Yes ☐No
{If Yes, Group Health Plan continues to pay primary during the 30 month coordination period. If No, initial entitlement is based on age or disability.}

Does the working aged or disability MSP provision apply? ☐Yes ☐No
{If Yes, Group Health Plan continues to pay primary during the 30-month coordination period. If No, Medicare is primary.}

Information provided by:

Name: ______
Address / Street: ______
City / State / Zip: ______
Phone: (________) ______ E-mail: ______
Signed: >>>>>>> ______

Verified By: ______ Date: ______

MSP 12/07