

MEDICARE SECONDARY PAYER QUESTIONNAIRE  
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_

If any answer to questions 1a through 4 is yes, the corresponding section of the "Other Insurance" form must be filled out completely.

1. Is the patient a Veteran?

a. Did the VA refer you here for treatment?

b. Does the patient have a VA "fee basis Id card"?

2. Do you have a Federal Black Lung Card?

3. Is this medical condition due to an accident of any kind?

If yes was it: Work Related \_\_\_\_\_ Auto \_\_\_\_\_ Injured in own home \_\_\_\_\_ Other \_\_\_\_\_

4. Is the patient covered by a health insurance plan through their own current employment or that of a family member? (Not retiree coverage)

Information obtained in questions 5 through 7 should be used when coding your claim for Medicare.

5. Is the patient employed?

If no, did you retire in the last two years?

If yes, give retirement date. \_\_\_\_\_

6. Is the spouse employed?

If no, did your spouse retire in the last two years?

If yes, give retirement date. \_\_\_\_\_

7. Please check the reason the patient is Medicare eligible: