MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient's Name: _____ Med. Rec. No.: _____

1. Is the patient covered by Veterans Administration, Blank Lung, or Workers Compensation? *Paciente cubierto por la Administración de Veteranos* ☐ Yes ☐ No
   A. Date of Workers Compensation Accident?_____
   Fecha del accidente
2. Was illness due to an injury? ☐ Yes ☐ No *La enfermedad se debe a un golpe/accidente*
   A. Date of Accident? _____ / _____ / _____ *Fecha del accidente*
   B. What type of accident caused illness/injury? If fall, explain in detail. *Explique tipo de accidente, si fue una caida explique detalladamente.*

      _____

      _____

      _____

   C. Is the patient filing or intending to file a liability suit? ☐ Yes ☐ No *Hará el paciente una demanda? Escriba el nombre del abogado.*
      If yes, give name, address and telephone number of attorney?
      Name of the attorney: _____
      Address: _____
      Telephone No.: _____

3. Is the patient employed (Medicare disabled beneficiaries under age 65 or Medicare beneficiaries over 65) and covered by a group health plan? ☐ Yes ☐ No
   El paciente trabaja, o está cubierto por un seguro de grupo.
   A. Date of retirement: _____ / _____ / _____ *Fecha del retiro*
   B. Is the patient married? ☐ Yes ☐ No *Casado*
   C. Is the spouse employed? ☐ Yes ☐ No *Esposa/o trabaja*
   D. Does the spouse have group coverage? ☐ Yes ☐ No *El esposo/a tiene seguro*
   E. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? ☐ Yes ☐ No *Tiene el paciente seguro a travez de la esposa, padres or guardian.*
   F. If you answered yes to either 3, 3D, 3E you will need to fill out the information below: *(Si es aplicable, llene los datos de la Compañía de Seguro)*

   Insurance Company: _____
   Address: _____
   Policy/Certification Number: _____
   Group Name: _____
   Group Number: _____

4. Is the patient entitled to benefits solely on the basis of end state renal disease? ☐ Yes ☐ No *El paciente recibe los beneficios, solo por problemas renales.*
   A. Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No *El paciente está en dialysis por más de 12 meses.*

(REMEMBER IT IS THE AGENCY'S RESPONSIBILITY TO BILL PRIMARY INSURERS)

Patient's Signature: _____ Date: _____

Remarks: _____

_____

Professional Home Services, Inc.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

INSTRUCTIONS,. Carefully address every question. Verity beneficiary Insurance cards and record information on the other page **EXACTLY** as it reads on the card(s). *Responda las preguntas cuidadosamente:*

PART I

1 Are you receiving Black Lung (LC) benefits?
Esta recibiendo beneficios del programa "Black Lung"?

❑ YES; Date benefits began: _____

BLACK LUNG IS PRIMARY ONLY FOR CLAIMS RELATED TO BLACK LUNG.

❑ NO

2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care in this facility?
Tiene contrato con el Dpto de Veteranos?

❑YES; **DVA IS PRIMARY FOR THESE SERVICES.**

❑ NO

3, Was the Illness/injury due to a work related accident/ condition? *Su tratamiento esta relacionado con un accidente de trabajo.*

❑ Yes; Date of illness/accident _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, COMPLETE WC INFORMATION, THEN COMPLETE NAME AND ADDRESS OF EMPLOYER IN PART IV, NUMBER 1. GO TO PART III.

☐ NO; GO TO PART II.

PART II

1. Was Illness/injury due to a non-work related accident?
Su tratamiento esta relacionado con un accidente (no de trabajo)

❑YES; Date of accident _____

❑ NO; GO TO PART III.

2. What type of accident caused the illness/injury?
Que tipo de accidente?

❑Automobile ☐ Non-Automobile ☐ Other _____

NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT

• COMPLETE NO FAULT INSURER INFORMATION, THEN GO TO PART III.

3. Was another party responsible for this accident?
Hay otra parte responsable?

❑ YES **LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.** COMPLETE INSURER INFORMATION. THEN GO TO PART III.

☐ NO; GO TO PART III.

PART III

1 . Are you enrolled in an HMO? *Pertenece a un HMO?*

☐ YES; Complete HMO Insurance information on the reverse.

☐ NO

PART III (Cont'd.)

2. Are you entitled to Medicare based on: *tiene Medicare por:*

☐ Age: GO TO PART IV *(Edad)*

☐ Disability: GO TO PART V *(Desabilitado)*

☐ ESRD: GO TO PART VI

PART IV - Age

1. Are you currently employed? *Esta empleado actualmente?*

❑ YES; Name and address of employer

_____

_____

_____

☐ NO; Date of retirement: _____

2. Is your spouse currently employed? *Su conyugue está empleado?*

☐ **YES;** Name and address of employer

_____

_____

_____

☐ NO; Data of retirement: _____

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. STOP; DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? *Tiene Seguro Médico, basado en usted o su conyugue?*

☐ YES

☐ NO; **STOP, MEDICARE IS PRIMARY PAYER** UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 20 or more employees? *Tiene su empleador más de 20 empleados?*

☐ **YES; STOP GROUP HEALTH PLAN IS PRIMARY.** COMPLETE THE GROUP HEALTH INSURANCE PLAN INFORMATION.

☐ NO: **STOP. MEDICARE IS PRIMARY PAYER** UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OH II.

PART I Organization **PART 2** Patient/Client

PATIENT/CLIENT NAME: **Last, First, Middle Initial**	**ID#**

Professional Home Services, Inc.

MEDICARE SECONDARY PAYER QUESTIONNAIRE (Cont'd.)

PART V (Disability)

1 . Are you currently employed? *Está empleado?*

☐ YES, Name and address of employer.

_____

_____

_____

☐ NO; Date of retirement:_____

2. Is a family Member currently employed? *Tiene algún familiar empleado?*

❑YES- Name and address of employer.

_____

_____

_____

❑ NO

IF THE PATIENT ANSWERS "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II, **STOP,** DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) Coverage based on your own, or a family member's current employment? *Tiene seguro médico por usted o familiar?*

☐ YES

☐ NO; **STOP. MEDICARE IS PRIMARY PAYER** UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 1 00 or more employees? *Tiene su empleador más de 100 empleados?*

☐ **YES; STOP, GROUP HEALTH PLAN IS PRIMARY PAYER** COMPLETE GHP INFORMATION BELOW.

☐ NO; STOP MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI (ESRD)

1 . Do you have group health plan (GHP) coverage? *Tiene seguro de grupo?*

❑YES; Name and address of employer, if any, from which you receive GHP coverage.

_____

_____

_____

☐ NO; **STOP, MEDICARE IS PRIMARY PAYER.**

2. Are you within the 30-Month coordination period? *Está dentro del período de 30 meses de coordinación?*

☐ YES

❑ NO; **STOP. MEDICARE IS PRIMARY PAYER.**

3. Are you entitled to Medicare On the: basis of either ESRD and age OR ESRD and disability? *Tiene Medicare por ESRD y edad o ESRD e incapacidad?*

☐ YES ❑ NO; **STOP- MEDICARE IS PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.**

4. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? *Tiene Medicare por ESRD simultaneamente?*

❑ **YES; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

❑ NO; INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY

5- Does the working aged or disability MSP provision apply (i.e. is the GHP primary based on age or disability entitlement)? *Aplica los años trabajados o incapacidad (MSP)?*

☐ YES; GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

❑ NO- MEDICARE CONTINUES TO PAY PRIMARY.

MEDICARE HEALTH INSURANCE - SOCIAL SECURITY ACT

Name (EXACTLY as printed on Medicare card) *Nombre:* _____

Medicare claim #_____ Sex: ☐ Male ☐ Female

Is entitled to: _____ Effective Date _____

Check all types of insurance that apply. Complete information requested for each insurance checked. *Seguros Médicos:*

ADDITIONAL INSURANCE	COMPANY NAME/ADDRESS	POLICY ID NUMBER	GROUP NO.	BENEFIT CODE (If any)	CONTACT NAME PHONE NUMBER
❑ Workman's Compensation (See front for related employer) ❑ No-Fault Insurer Claim No._____ ❑ Liability Insurer Claim No,_____ ❑ Employer's Group Health Insurance Plan Policy Owner_____ Relationship to Patient_____ ☐ HMO ❑ Supplemental Insurance ❑ Other Health Insurance					

Patient/Client Signature *(Optional)* _____ Date: / /

Signature of Person Completing Form: _____ Date: / /

MEDICARE SECONDARY PAYER WORKSHEET

PART 1

1. Are you receiving Black Lung (BL) Benefits?
   ❑ Yes; Date benefits began: ____ ____ ____ ____ __
   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL. ❑ No
2. Are the services to be paid by a government program such as a research grant? ❑ Yes; Government Program will pay primary benefits for these services. ❑ No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ❑ Yes. DVA IS PRIMARY FOR THESE SERVICES. ❑ No
4. Was the illness/injury due to work related accident/condition?
   ❑ Yes; Date of injury/illness: ____ ____ _ ***Complete payer information below.*** WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.
   GO TO PART 3 ❑ No
   GO TO PART 2

PART 2

1. Was illness/injury due to a non-work related accident?
   ❑ Yes- Date of accident: ____ ____ ____ ❑ No **GO TO *PART 3***
2. What type of accident caused the illness/injury?
   ❑ Automobile ❑ Non-automobile ***Complete payer information below.*** NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. ***GO TO PART 3***
   ❑ Other
3. Was **another party responsible** for this accident? ❑ Yes;
   Complete payer information below. LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.
   GO TO PART 3 ❑ No ***GO TO PART 3***

PART 3

1. Are you entitled to Medicare based on: ❑ Age ***GO TO PART 4***
   ❑ Disability ***GO TO PART 5*** ❑ ESRD ***GO TO PART 6***

PART 4- Age

1. Are you currently employed? ❑ Yes. **Complete payer info below.**
   ❑ No. Date of retirement: ____ ____ ____ ❑ No. Never employed.
2. Is your spouse currently employed? ❑ Yes. **Complete payer info below.** ❑ No. Date of retirement: ____ ____ ____
   ❑ No. Never employed. IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART 1 OR 2. DO NOT PROCEED ANY FURTHER.
3. Do you have **group health plan** (GHP) coverage based on your own, or a spouse's, current employment? ❑ Yes.
   ❑ No. STOP MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART 1 OR 2.
4. Does the employer that sponsors your **GHP employ 20 or more** employees? ❑ Yes STOP **GHP IS PRIMARY.**
   Complete payer information below.
   ❑ No. STOP MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART 1 OR 2.

PART 5 - Disability

1. Are you currently employed? ❑ Yes. **Complete payer info below.**
   ❑ No. Date of Retirement: ____ ____ __ ❑ No. Never employed.
2. If married, is your spouse currently employed? ❑ Yes. Complete payer info below. ❑ No. Date of Retirement:
   ❑ No. Never employed. IF THE PATIENT ANSWERS "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART 1 OR 2. DO NOT PROCEED ANY FURTHER. STOP
3. Do you have group health plan (GHP) coverage based on your own, or a family member's, current employment? ❑ Yes.
   ❑ No. STOP MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR 2.
4. Are you covered under the group health plan of a family member other than your spouse? ❑ Yes. **Complete payer information** below. ❑ No.
5. Does the employer that sponsors your GHP employ 100 or more employees? ☐ Yes. STOP GROUP HEALTH PLAN IS PRIMARY.
   Complete payer information below.
   ❑ No. STOP MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART 1 OR 2.

PART 6 - ESRD

1. Do you have **group health plan** (GHP) coverage?
   If yes, **Complete payer information below.**
   ❑ No. STOP MEDICARE IS PRIMARY.
2. Have you received a **kidney transplant?**
   ❑ Yes. Date of transplant: ____ ____ _ ❑ No
3. Have you received maintenance dialysis treatments?
   ❑ Yes. Date dialysis began: ____ ____ ____ ____ ____ .
   If you participated in a self dialysis training program, provide date training started: ____ ____ ____ ❑ No
4. Are you within the 30 month coordination period that starts ____ ____ ____ ? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare, even if not yet enrolled in Medicare, because of kidney failure usually the 4th month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant).
   ❑ Yes. ❑ No. STOP **MEDICARE IS PRIMARY.**
5. Are you entitled to Medicare on the basis of either **ESRD and age** or **ESRD and disability?** ❑ Yes. ❑ No.
6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
   ❑ Yes. STOP GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   ❑ No. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.
7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?
   ❑ Yes. STOP GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   ❑ No. MEDICARE CONTINUES TO PAY PRIMARY.

PRIMARY PAYER INFORMATION

EMPLOYER (Patient): _____
Address: _____

EMPLOYER (Patient): _____
Address: _____

INSURER / GHP: _____ Address: _____

Policy identification number: (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policy holder/named insured: _____ Relationship to patient: _____

PATIENT NAME	PATIENT ID#	STAFF SIGNATURE	DATE