Medicare Secondary Payer Questionnaire

To determine if Medicare is the primary payer for your services, please answer the following questions. We appreciate your help in staying compliant with Medicare.

1. Are you receiving Black Lung (BL) Benefits?
   _____ YES
   _____ NO

2. Are the services to be paid by a government program such as a research grant?
   _____ YES
   _____ NO

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   _____ YES
   _____ NO

4. Was the illness/injury due to a work related accident/condition?
   _____ YES; Date of injury/illness: _____ (MM/DD/CCYY)
   Name and address of your employer:
   _____
   _____ NO

5. Was the illness/injury due to a non-work related accident?
   _____YES; Date of accident: _____ (MM/DD/CCYY)
   What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-automobile
   Location of accident: _____
   _____ NO

6. Are you entitled to Medicare Based on:
   _____ Age
   _____ Disability
   _____ ESRD

7. Do you have insurance coverage provided by your employer or your spouse's employer?
   _____ YES
   _____ NO

8. Are you currently in a Skilled Nursing Facility?
   _____ YES; Facility Name_____ Location _____
   _____ NO

I, _____verify that the questions above have
(Printed Name)
been completed to the best of my knowledge.

Patient Signature: _____ Date: _____