Account #:

Medicare Secondary Payer Questionnaire

1. Are you currently staying in a Skilled Nursing Facility?

☐ YES ☐ NO

If yes, what facility are you staying at? _____

2. Was the injury caused by a specific accident? If 'NO' proceed to question #3.

☐ YES ☐ NO

If you answered 'YES' to #2, please answer the following questions:

2a. Date of injury: _____

2b. Was the injury due to:

☐ WORK RELATED ACCIDENT

☐ AUTOMOBILE ACCIDENT

☐ OTHER: _____

2c. Was an insurance claim filed for this accident?

☐ YES If yes, please provide us with the claim information.

☐ NO

3. Are you entitled to Medicare based on:

☐ AGE

☐ DISABILITY

☐ END STAGE RENAL DISEASE (ESRD)

4. Do you have group health plan coverage based on your own or a spouse's **CURRENT** employment?

☐ YES ☐ NO

5. Are you receiving Black Lung (BL) Benefits?

☐ YES ☐ NO

6. Are the services to be paid by a government program, such as a research grant?

☐ YES ☐ NO

7. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

☐ YES ☐ NO

Printed name: _____

Patient signature: _____ Date: _____