MEDICARE SECONARY PAYOR QUESTIONNAIRE

Complete ONLY if you have Medicare Part B coverage.

Patient Name: ______________________________ DOB: ____________

Part I

1. Are you entitled to Medicare based on:
   - ☐ Age. **Go to part II**.
   - ☐ Disability**. Go to part III.**
   - ☐ ESRD (End stage renal disease, kidney failure) **Go to part IV**.

Part II- AGE

1. Are you currently employed?
   - ☐ Yes. Name and address of your employer: ______________________________
   - ☐ No. Date of retirement: ______/_____/_____
   - ☐ No. Never employed.

2. Is your spouse currently employed?
   - ☐ Yes. Name and address of spouse's employer: ______________________________
   - ☐ No. Date of retirement: ______/______/________
   - ☐ No. Never employed.

If you answered no to both questions 1 and 2, **stop, Medicare is primary. Sign back page and return form.**
If you answered yes to 1 or 2 please continue.

3. Do you have group health plan coverage based on your own, or a spouse's current employment?
   - ☐ Yes.
   - ☐ No. **Stop. Medicare is primary. Sign back page and return form.**

4. Does the employer that sponsors your group health plan employ 20 or more employees?
   - ☐ Yes. Stop. **Group health plan is primary**. Please give the following information.
     Name and address of group health plan: ______________________________
     Policy ID #: ____________________ Group ID#: ____________________
     Name of policyholder: ____________________ Relationship to patient: ____________
   - ☐ No. **Stop. Medicare is primary. Sign back page and return form.**

Part III- Disability

1. Are you currently employed?
   - ☐ Yes. Name and address of your employer: ______________________________
   - ☐ No. Date of retirement: _____/_____/_____

2. Is a family member currently employed?
   - ☐ Yes. Name and address of your employer: ______________________________
   - ☐ No.

If the patient answered no to both questions 1 and 2, **stop, Medicare is primary**. **Sign back page and return form.**

Continued on back

3. Do you have group health plan coverage based on your own, or a family member's current employment?
   - ☐ Yes.
   - ☐ No**. Stop. Medicare is primary**. **Sign bottom and return form.**

4. Does the employer that sponsors your group health plan employ 100 or more employees?
   - ☐ Yes. **Stop. Group health plan is primary**. Please give the following information.
     Name and address of group health plan: ______________________
     Policy ID#: ______________________ Group ID#: ______________________
     Name of policyholder: ______________________ Relationship to patient: ______________________
   - ☐ No. **Stop. Medicare is primary**. **Sign bottom and return form.**

Part IV – ESRD (End Stage Renal Disease)

1. Do you have group health plan coverage?
   - ☐ Yes. Name and address of group health plan: ______________________
     Policy ID#: ______________________ Group ID#: ______________________
     Name of policyholder: ______________________ Relationship to patient: ______________________
     Name and address of employer, if any, from which you receive group health coverage: ______________________
     ____
   - ☐ No. **Stop. Medicare is primary**. **Sign bottom and return form.**

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?
   - ☐ Yes.
   - ☐ No. **Stop. Medicare is primary. Sign bottom and return form.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   - ☐ Yes.
   - ☐ No. **Stop. Group health plan is primary during the 30 month coordination period**. **Sign bottom and return form.**

6. Was your initial entitlement to Medicare based on ESRD?
   - ☐ Yes. **Stop. Group health plan continues to pay primary during the 30 month coordination period. Sign bottom and return form.**
   - ☐ No. Initial entitlement based on age or disability.

7. Does the working aged or disability provisions apply, or is the group health plan primarily based on age or disability entitlement?
   - ☐ Yes. **Group health plan continues to pay primary during the 30 month coordination period. Sign bottom and return form.**
   - ☐ No. **Medicare continues to pay primary. Sign bottom and return form.**

I affirm that the above information is true and correct to the best of my knowledge.

______________________________________ ______________________
Patient/Legally Authorized Person Signature Date

____
Print Name & Relationship to Patient

01/08