**Ability Health Services:** MEDICARE SECONDARY PAYOR QUESTIONNAIRE FORM

1. Are you receiving Home Health Care (nursing, therapy)? _____ NO
   _____ YES Date began: _____________ **STOP!**
   Patient can not be receiving both, out patient therapies and in home care.

2. HAVE YOU RECEIVED ANY HOME THERAPY??? _____ NO
   (*Front Desk-please call to confirm Discharge Date*) _____ YES Location:_______________________
   Date last seen?____________________

3. Have you received any therapy in or out of State? _____ NO
   _____ YES Location:_______________________
   Date last seen?____________________

4. Are services to be paid by a government program such as research grant? ___ Yes; **STOP!**, Government Program will pay primary benefits for these services. ____ NO, Please go to the next question.

5. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   _____ YES **STOP!** Government will pay primary benefits.
   _____ NO Please go to the next question

6. Was this due to Illness or Injury due to **WORK** related accident? _____ **NO** Please, go to the next question
   _____ YES Date began: ____________

Name and address of

The WC plan: ______________________________________________________________
Claim# ________________ Employer Name and number: ________________________________________

7. Was this due to a fall, injury or any other form of an accident?
   _____ **YES** **Date began: __________ Go to question #8 and describe.**
   _____ NO Please go to the question #9

8. How and where did the accident happen?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

9. Are you entitled to Medicare based on: ____ Age Date of Retirement: _______________________
   ____ Disability Date of Disability: _______________________
   ____ ESRD

10. Are you currently employed? _____ YES ______ NO

If yes please provide name and number of employer: ____________________________________________

11. Is spouse employed? _____ NO
    (If yes, do you have group health plan coverage, based on your own or spouses current employment)
    _____ YES **STOP!** Medicare is not primary, get other Ins. Info.

_________________________________________ _________________________________________

PATIENT'S SIGNATURE DATE WITNESS SIGNATURE DATE