ABILITY HEALTH SERVICES, INC.

MEDICARE SECONDARY PAYOR QUESTIONAIRE 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??? ____ YES Date Last seen?_____ **STOP**!
   _____ No.

3. 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.

4. 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

5. 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: _____.

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

7. How and where did the accident happen?
   _____
   _____
   _____
   _____

8. Are you entitled to Medicare based on: ____ Age Date of Retirement: _____?
   ____ Disability Date of Disability _____
   ____ ESRD

9. Are you currently employed? _____ YES _____ NO
   If yes, please provide name and number of employer: _____

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

_____ _____
Patient/Guardian Signature Date Witness Signature Date