Medicare Secondary Payor

As part of our participation in the Medicare program, we are required to ask each of these questions to confirm that Medicare should act .as your primary insurance coverage. Under our agreement with Medicare, we must also reverify the answers to these questions every 90 days or at the start of a new injury.

This form is not required if you are enrolled in a Medicare Advantage Plan.

Patient: _____ _____ **DOB:** _____ _____
Account: _____

Yes	No	
☐	☐	1. Are you receiving Black Lung Benefits?
☐	☐	2. Are your services to be paid for by a Governmental Research Program?
☐	☐	3. Are you entitled to benefits through the Department of Veteran Affairs?
☐	☐	4. Is your therapy related to a non-work accident?

- If so, what date did it occur? _____

☐ ☐ 5. Is your therapy related to work injuries or illnesses?

- If so, what date did it occur? _____
- And the name of the employer? _____

☐ ☐ 6. Is your therapy related to an injury or illness covered under an automobile or premise (Home or Business) insurance? If YES, what is the name of the Insurance and claim number?
Ins. _____ Claim No. _____

☐ ☐ 7. Do you believe that another party is responsible for your injury/Illness? If YES, what is the name of the Insurance and claim number?
Ins. _____ Claim No. _____

☐ ☐ 8. Do you have a group health plan insurance based on your own current employment, or the employment of either your spouse or other family member? If YES, how many employees, including yourself or spouse work for the employer from whom you have Group Health Insurance.

☐ **1-19** ☐ **20-99** ☐ **100 or More**

☐ ☐ 9. Are you under 65 AND on Medicare due to DISABILITY and covered by Group Health?

☐ ☐ 10. Are you under 65 and on Medicare for ESRD (end stage renal disease) diagnosis?

If YES, what was the date of your diagnosis? _____

Have you received maintenance dialysis treatments? _____

If YES, what date did your dialysis begin? _____

Have you received a Kidney Transplant? _____

If YES, what was the date of your transplant? _____

Patient Signature: _____ Date: _____

Patient initials reverification if above signature is >= 90 DAYS _____ Date: _____