Medicare Secondary Payor Questionnaire (MSP)

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 Name: ____ **DOB:** ___________________

Account Number: __________________________

☐ YES ☐ NO 1. Are you receiving Black Lung Benefits?

☐ YES ☐ NO 2. Are your services to be paid for by a Governmental Research Program?

☐ YES ☐ NO 3. Are you entitled to benefits through the Department of Veteran Affairs?

☐ YES ☐ NO 4. Is your therapy related to a non-work accident?

☐ YES ☐ NO 5. Is your therapy related to a work-related accident or condition?

☐ YES ☐ NO 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. _____________________

☐ YES ☐ 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. _____________________

☐ YES ☐ 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**

☐ YES ☐ NO 9. Are you under 65 and on Medicare due to DISABILITY and covered by Group Health Insurance?

☐ YES ☐ NO 10. Are you under 65 and on Medicare for an End State Renal Disease (ESRD) 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: ___________