PIEDMONT INTERNAL MEDICINE

# MEDICARE SECONDARY PAYER QUESTIONNAIRE

**Date:** _____

**Patient Name:** _____ **Birth Date:** _____

Medicare requires that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items provided. Therefore, Piedmont Internal Medicine is requesting that the information below be completed so that a determination can be made if Medicare is the primary insurance, please answer all the questions.

| | ***Please check all that apply:*** | Yes | No |
|---|---|---|---|
| 1. | Is the illness/injury due to an automobile accident, liability accident, or Workman's Compensation? | ☐ | ☐ |
| 2. | Is illness covered by the Black Lung Program or Veterans Administration program? | ☐ | ☐ |
| 3. | Are the services to be paid by a government research/ grant program? | ☐ | ☐ |
| 4. | Is the patient covered by an employer group health plan (EGHP), including Federal Employees? | ☐ | ☐ |
| 5. | Is this patient or his/her spouse actively employed by an employer of 20 or more employees? | ☐ | ☐ |
| 6a. | If under age 65, is your Medicare coverage due to disability? *If "yes" go to #6b, if "no", go to #7.* | ☐ | ☐ |
| 6b. | Is the patient or his/her spouse or parent actively employed by, or is the patient considered an employee of an employer having 100 or more employees? *If "yes", please complete information below.* | ☐ | ☐ |
| 7a. | Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? *If "yes", go to #7b* | ☐ | ☐ |
| 7b. | Has the patient completed the ESRD coordination period? *If "no", enter information below.* | ☐ | ☐ |

***If you answered "Yes" to any of the above questions, please complete the following:***

Name of Insurance Company: _____

Street Address of Insurance Company: _____

City, State, Zip Code: _____ Telephone: _____

Name of Policy Holder: _____

Street Address of Insurance Company: _____

City, State, Zip Code: _____ Telephone: _____

Relationship to Patient: _____ Date of Birth of Policy Holder: _____

Insurance I.D. Number: _____ Group Number: _____

If Accident/Injury, Date of Accident/Injury: _____ Do you have an attorney? ☐ Yes ☐ No

Attorney Name and Contact: _____

Name of Research/Grant Study: _____

Patient Signature: _____