ENT & ALLERGY SPECIALISTS OF VIRGINIA
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Medicare Secondary Payer Questionnaire

What is the Medicare Secondary Payer Questionnaire?

- A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.
- Completion is required by Medicare in any situation where the patient has other insurance that may pay your medical bills before Medicare.

Patient Name _____

Date of Birth _____

Today's Date _____

Please complete both sides of form:

1. Are you currently employed? _____ Yes Date of retirement _____/_____/_____
   _____ No *(if no skip to #4)*
2. Does your present or former employer offer health insurance? _____ Yes _____ No
   (if no skip to #4)

3. Does the employer that sponsors your Group Health Plan employ 20 or more employees?
   _____Yes**;** if yes, **GROUP HEALTH PLAN IS PRIMARY**

   Name and address of employer:

   Employer Phone #:

   Name and address of Group Health Plan:

   Policy ID #:
   Group ID #:

4. Do you have group Health plan coverage based on your spouse's or parent's current or former employer? _____ Yes _____ No *(if no skip to #6)*

5. Does the employer that sponsors your spouse's or parent's Group Health Plan employ 20 or more employees? _____ Yes; if yes, **GROUP HEALTH PLAN IS PRIMARY**

   Name and address of Group Health Plan:

Policy ID #:
Group ID #:
Name of policy-holder:
Relationship to patient:

Please turn form over to complete

6. Was your illness or injury due to a work-related accident or condition? _____Yes
_____ No *(if no skip to #7)*

Provide work comp information if Yes:

Work comp plan:

Case or claim #:

Claim Adjuster name & phone #:

7. Was your illness or injury due to a NON-work related accident? _____Yes
_____ No *(if no skip to #9)*

8. What type of accident caused the illness or injury?

_____ Automobile

_____ Non-automobile

Name and address of no-fault or liability insurer:

Insurance claim number

Insurance phone number

9. Are you entitled to Medicare based on disability? _____ Yes _____ No
10. Are you receiving Black Lung Benefits? _____ Yes Date benefits began _____/_____/_____
_____ No
11. Have you received a kidney transplant? _____Yes Date of transplant _____/_____/_____
_____ No
12. Do you have End Stage Renal Disease? _____ Yes _____ No
Have you received maintenance dialysis treatments for End Stage Renal Disease?
_____ Yes Date dialysis began _____/_____/_____
_____ No
13. Are you within 30-month coordination period for End Stage Renal Disease Medicare Benefits?
_____ Yes _____ No

FOR CLAIMS RELATED TO WORK COMP RELATED ACCIDENT OR INJURY, NO-FAULT OR LIABILITY, BLACK LUNG DISEASE, OR END STAGE RENAL DISEASE MEDICARE WILL BE SECONDARY PAYER.