MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Patient Name: Date:

Health Insurance Claim Number (HICN):

NOTE: Medicare law requires we determine if another insurer might cover your medical services.
In order to assist us in the correct billing of these services, please answer the following questions.

No	Yes		
		Is your injury/illness due to a work-related accident/condition	
		Is your injury/illness due to an automobile accident	
		Is your injury/illness due to an accident other than an automobile accident	
		Is your injury/illness due to the fault of another party	
		If yes, complete:	
		Name of Insurer:	Address
		Policy #	Accident Date: Accident Location:
		Covered under the Federal Black Lung Program	
		Are you eligible for coverage under the Veteran's Administration	
		Are you currently employed?	If no, Date of retirement & insurance ended:
			If yes, employer name & address:
			Employer phone number (if known):
			Number of employees: ☐ 0-19 ☐ 20-99 ☐ 100 or more
			If you are have or had an employer group health plan:
			Name and address of insurance:
			Policy #: Group #
			Date coverage began: Date coverage ended:
		If married, is your spouse currently employed? ☐ No spouse	If no, date of retirement & insurance ended:
			If yes, employer name & address:
			Employer phone number (if known):
			Number of employees: ☐ 0-19 ☐ 20-99 ☐ 100 or more
			If your spouse has or had an employer group health plan:
			Name and address of insurance
			Policy #: Group #
			Date coverage began: Date coverage ended:
		Are you a dependent covered under a parent's/guardian's	If no, Date of retirement & insurance ended:
			If yes, employer name & address:
			Employer Phone number (if known):
			Number of employees: ☐ 0-19 ☐ 20-99 ☐ 100 or more
			If your parent/guardian has or had an employer group health plan:
			Name and address of insurance
			Policy #: Group #
			Date coverage began: Date coverage ended:

Thank you for your cooperation in ensuring that your medical services will be billed correctly.

Your Signature: Date: