

Medicare Secondary Payer Form

Patient Name: _____

Date of Birth: _____

*** Medicare requires that all questions be answered in order to confirm that Medicare is the primary payer of your medical bills.

1. Do you receive Veteran's Benefits? Yes No

2. Are you receiving benefits under the Black Lung Program? Yes No

If yes, date benefits began: _____

If yes, date of injury/illness: _____

3. Was this injury due to a work related accident/condition? Yes No

If yes, date of injury/illness: _____

4. Was this injury related to an automobile accident? Yes No

If yes, date of accident: _____

5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? Yes No

If yes, please provide: Attorney's name: _____

Address: _____

Phone number: _____

6. Are you entitled to Medicare based on: Age (65 & over)- go to question 7

Disability – go to question 7

End Stage Renal Disease

Do you have group health plan coverage? Yes No

Are you within the 30-month coordination period? Yes No

7. Are you currently employed? Yes No (Date of Retirement: _____)

Is your spouse currently employed? Yes No

Do you have a group health plan as primary coverage based on your own or a spouse's current employment? Yes No

If you answered **YES** to questions #3, #4 or #7 above, please complete the following information:

Insurance company: _____

Address: _____

Phone number _____

Policy number: _____ Group number: _____

Patients Signature

Date