

## Medicare Secondary Payer Questionnaire

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

Dear Medicare Patient:

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, Nova Southeastern University (NSU) is requesting that the below information be completed so that a determination can be made if Medicare is your primary insurance, please answer all questions.

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

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**Please complete each question, if applicable.**

Name of Primary Insurance Company: \_\_\_\_\_

Address of Primary Insurance Company \_\_\_\_\_

Name of Primary Insurance Policy Holder: \_\_\_\_\_

Primary Insurance Policy Number: \_\_\_\_\_

Name of Policy Holder's Employer: \_\_\_\_\_

Address of Policy Holder's Employer: \_\_\_\_\_

Date Benefits Began \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Accident/Injury (If answered "yes" see question #1):\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of attorney(s) (If answered "yes" to question to question #1): \_\_\_\_\_

\_\_\_\_\_

Name of Research/Grant Study (If answered yes to question (#3):\_\_\_\_\_

Patient's Signature \_\_\_\_\_