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 _____________________________________________________________