**CLINTON SERVICE UNIT**

**Medicare Secondary Payer Questionnaire**

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare

Patient Name: _____ Signature: _____

Medicare Policy Number: _____

Health Record Number: _____ Date: _____ D.O.B.: _____

*Check All That Apply:*

**Part 1**

**Are you receiving benefits from any of the following programs?**

| | | |
|---|---|---|
| Black Lung | ☐ YES* | ☐ NO |
| Government Research Grant | ☐ YES* | ☐ NO |
| Veterans Affairs | ☐ YES* | ☐ NO |
| Injury/Illness related to work-related accident/condition | ☐ YES* | ☐ NO |

*** IF you answered YES to any of the above, please complete PART 1 of long form**

**Part 2**

**Was the injury/illness due to a non-work-related accident/condition?**

☐ YES (complete Part 2 of long form) ☐ NO

**Was the injury/illness due to a work-related accident/condition?**

☐ YES (complete Part 1 of long form) ☐ NO

**Part 3**

**Are you entitled to Medicare as a result of:**

| | |
|---|---|
| Age | ☐ YES |
| Disability | ☐ YES (complete Part 6 of long form) |
| End-Stage Renal Disease (ESRD) | ☐ YES (complete Part 5 of long form) |

**Part 4**

**Are you currently employed?** ☐ YES (answer next question) ☐ NO

**Do you have group health plan (GHP) coverage based on your employer?**

☐ YES ☐ NO

**If yes, are there under or over 20 employees?**

☐ OVER (do Part 4 of long form) ☐ UNDER

**Do you have a spouse, who is currently employed?**

☐ YES(answer next question) ☐ NO ☐ Yes-not employed

**Does your spouse have group health plan (GHP) coverage?** ☐ YES ☐ NO

**If yes, are there under or over 20 employees?**

☐ OVER (Long form Part 4) ☐ UNDER