Medicare Secondary Payer Questionnaire

Name: _____ Date: _____

DOB: _____ MRN: _____

ATTENTION MEDICARE RECIPIENTS

Medicare has put forth guidelines for Health Care Providers to follow in determining whether services rendered are to be billed as primary or secondary to Medicare. To ensure compliance with these guidelines from Medicare, we have included a brief questionnaire as part of your registration information packet. We ask that you complete the brief questionnaire below and return this form to the front desk staff. This questionnaire will be kept on file in your chart and reviewed yearly for any changes.

Thank you for your cooperation.

MEDIGAP BENEFIT AUTHORIZATION

I request that payment of authorized MediGap benefits be made on my behalf to Pratt Healthcare for any services furnished to me by any physician/supplier. I authorize any holder of medical information about me to release to _____
(Name of secondary policy)

any information needed to determine these benefits or the benefits payable for related services.

MEDICARE BILLING QUESTIONNAIRE

		YES	NO
1)	Do you have any Medical Insurance other than Medicare?	❑	❑

If yes, what Insurance are you covered by?

Insurance Name: Group/Plan No.:

Name of Policyholder: Relationship to Policyholder:

		YES	NO
2)	Are you/your spouse working/employed **and** receiving employee health benefits	❑	❑

If yes, please give the name of the employer:

How many employees work for the company providing your health insurance benefits?

❑ Less than 20 Employees ❑ 20 to 99 Employees ❑ 100 or more Employees

		YES	NO
3a)	Is the illness or injury you are being treated for due to a work-related accident or condition that is covered by:		
	Workers Compensation	❑	❑
	Public Health Service or other Federal Agency	❑	❑
	Black Lung Benefits (If yes, please give effective date: _____)	❑	❑
	Veteran Affairs	❑	❑

If you answered yes to any of the above, please provide the following:

Insurance Name: _____ Claim/Policy No.: _____

Employer Name & Address _____

_____

		YES	NO
3b)	If you answered no to all of the above, was the illness or injury due to a non-work related injury?	❑	❑

If yes, please specify the date and nature of the accident which caused the injury/illness:

		YES	NO
	Is there any liability coverage?	❑	❑

If yes, please specify: No Fault Insurance (Including Auto Insurance)
Other Liability Insurance

Insurance Name: _____ Claim Policy No.: _____

		YES	NO
4)	Is your Medicare eligibility based solely on a disability?	❑	❑

If yes, please specify the date the disability began:

		YES	NO
5)	Is your Medicare eligibility based solely on End Stage Renal Disease?	❑	❑

If yes, please specify the date dialysis or disability began:

Signature: _____ Date: _____