Medicare Secondary Payer Questionnaire

Please print:

Name: Date of Birth: ___ Age

1. Are you employed? ☐ Y ☐ N If no, and you are retired, please give retirement date:

2. Are you covered by a group health insurance plan through anyone’s current employer? ☐ Y ☐ N

Name/Address of Insurance:

Name of Policy Owner: Relation: ID#: 

Name of Employer:

Number of employees: ☐ 1-19 ☐ 20-49 ☐ 50-99 ☐ 100+

3. If you are under 65 years of age, are you disabled? ☐ Y ☐ N If yes, date last worked:

4. Is today’s visit related to and/or authorized by:

Government Research Grant ☐ Y ☐ N Black Lung Program ☐ Y ☐ N

Veterans Affairs (VA) ☐ Y ☐ N Native American Health Plan ☐ Y ☐ N

Other Government program (other than Medicaid): ☐ Y ☐ N

If yes, specify which program:

5. Do you have End Stage Renal Disease that has been diagnosed within the past 30 months? ☐ Y ☐ N

Date of first dialysis treatment:

Date of self-dialysis training:

Date of kidney transplant:

6. If your spouse is retired, please answer:

Spouse’s Name: Retirement Date:

7. Is today’s visit due to any type of accident? ☐ Y ☐ N

If yes, what kind: ☐ Auto ☐ Job Related ☐ Liability (other party is responsible) ☐ Other

Date of injury/illness:

Description of accident:

Date: Initials ___ Date: Initials ___ Date: Initials ___
Date: Initials ___ Date: Initials ___ Date: Initials ___
Date: Initials ___ Date: Initials ___ Date: Initials ___

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Forms Manual
Education Services Department
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