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	_