Date:________________

MENORAH PARK
OUTPATIENT THERAPY SERVICES
MEDICARE SECONDARY PAYOR QUESTIONNAIRE

PART 1

1. Are you receiving Black Lung (BL) Benefits?
   ☐ Yes; date benefits began: _________

BL IS PRIMARY FOR CLAIMS RELATED TO BL

   ☐ No
2. Are the services to be paid by a government program such as a research grant?
   ☐ Yes; Government Program will pay primary benefits for these services.
   ☐ No
3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   ☐ Yes

DVA IS PRIMARY FOR THESE SERVICES

   ☐ No
4. Was the illness/injury due to a work related accident/condition?
   ☐ Yes; date of illness/injury: _________
   Name and address of WC plan:
   ____
   Policy or identification number: ______________________________
   Name and address of your employer: ______________________________
   ____

   WC ISPRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART 3

   ☐ No. **Go to Part 2.**

PART 2

1. Was the illness/injury due to a non work related accident?
   ☐ Yes; Date of accident: __________________
   ☐ No, **Go to Part 3**
2. What type of accident caused the illness/injury?
   ☐ Automobile.
   ☐ Non-automobile.
   Name and address of no-fault or liability insurer:
   ____
   ____
   ____
   Insurance Claim Number: ________________________

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THIS ACCIDENT. GO TO PART 3.

   ☐ Other
3. Was another party responsible for this accident?
   ☐ Yes
   Name and address of any liability insurer: ______________________________
   Insurance claim number: ______________________________

   LIABILITY INSURER IS PRIMARY PAYOR ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART 3

   ☐ No

PART 3

1. Are you entitled to Medicare based on:
   ☐ Age **GO TO PART 4**
   ☐ Disability **GO TO PART 5**
   ☐ End Stage Renal Disease (ESRD) **GO TO PART 6.**

PART 4 - AGE

1. Are you currently employed?
   ☐ ☐Yes; Name and address of your employer: ______________________________
   ____
   ☐ ☐No Date of retirement: ____________
   ☐ ☐No *Never Employed*
   ☐ ☐No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 OR 2.**

PART 5 - DISABILITY

1. Are you currently employed?
   ☐ ☐Yes; Name and address of your employer: ______________________________
   ____
   ☐ ☐No; Date of retirement: ____________
2. Is a family member employed?
   ☐ ☐Yes; Name and address of employer: ______________________________
   ____
   ☐ ☐No

IF THE PATIENT ANSEWRED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1OR 2. DO NOT PROCEED ANY FURTHER.

1. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
   ☐Yes
   ☐ ☐No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART 1 OR 2.**
2. Is your spouse currently employed?
   ☐Yes; Name and address of employer: ______________________________
   ____
   ☐No Date of retirement: ____________
   ☐*No Never employed.*

IF THE PATIENT ANSEWRED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1OR 2. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
   ☐ ☐Yes.
   ☐No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 OR 2.**
4. Does the employer that sponsors your GHP employ 20 or more employees?
   ☐Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION,**

   Name and address of GHP:
   ____
   Policy Identification Number: ______________________________
   Group Identification Number: ______________________________
   Name of Policy Holder: ______________________________
   Relationship to Patient: ______________________________