## Medicare Secondary Payer Form

| DA   | TE F   | PATIENT NAME  |             |     |  |
|--|--|---|-------------|-----|--|
|  | •  |   |             |     |  |
| Dear Medicare Patient:   |  |   |             |     |  |
| As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance. |  |   |             |     |  |
| 1.   | Is the illness/jnjury due to an automob  | ile accident, liability accident or Workman's Compensa  | tion? 🗆 Yes | □No |  |
| 2.   | Is illness covered by the Black Lung F   | Program or Veterans Administration program?             | □Yes        | □No |  |
| 3.   | lf under 65, are you a renal dialysis pa   | atient in your first 30 months of Medicare entitlement? | □Yes        | □No |  |
| 4a.  | If under age 65, is your Medicare cover  | erage due to disability?                                | □Yes        | □No |  |
| 4b.  | Is patient covered by a large group he current employer?   | alth plan through patient's employer or spouse's        | □Yes        | □No |  |
| 5.   | If 65 and over, is patient covered by E current employer?  | imployer Group Health Plan through patient's or spous   | э's ПYes    | □No |  |
| Registrar Notes:   |  |   |             |     |  |
|  | A. If patient responds "no" to questions 1-5, Medicare is primary.  B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.   |   |             |     |  |
| Name of Insurance Company  |  |   |             |     |  |
| Address of Insurance Company   |  |   |             |     |  |
|  | Matter discount through the contract of the co |   |             |     |  |
| Name of Policy Holder  |  |   |             |     |  |
| Policy Number  |  |   |             |     |  |
| Policy Holder's Employer Name  |  |   |             |     |  |
| Pol  | Policy Holder's Employer Address   |   |             |     |  |
| Date of Accident (if applicable)   |  |   |             |     |  |
| Patient's Signature  |  |   |             |     |  |

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