# Medicare Secondary Payer Questionnaire

**(Short Form)**

**1. Are you receiving benefits from any of the following programs?**

| | |
|---|---|
| **Black Lung** | **____No____Yes** |
| **Research Grant** | **____No____Yes** |
| **Veteran Affairs** | **____No____Yes** |

**2. Was the illness/injury due to a work related accident/condition?**

**_____ No** **_____ Yes**

**Date of injury/illness: _____**

**3. Was illness/injury due to a non-work related accident?**

**_____ No** **_____ Yes**

**Date of accident: _____**

**What type of accident caused the illness/injury?**
**_____ Automobile**
**_____ Non-automobile**

**4. Are you entitled to Medicare based on:**

**_____ Age**
**_____ Disability**
**_____ End Stage Renal Disease**

**5. Are you currently employed? Check all that apply**

**(IF YES) check applicable**

**_____ No** **_____ Yes** **( ) Part-time or ( ) Full-time or ( ) Retired**

**6. Is your spouse currently employed? Check all that apply**

**(IF YES) check applicable**

**_____ No** **_____ Yes** **( ) Part-time or ( ) Full-time or ( ) Retired**

**7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment? Check all that apply**

**(IF YES) check applicable**

**_____ No** **_____ Yes** **( ) Current Employer ( ) Spouse's Employer ( ) Retirement Plan**

**8. Does the employer that sponsors your GHP employ 20 or more employees?**

**_____ No** **_____ Yes** **( ) GHP from a Retirement plan**

**9. Are you currently a patient in a skilled nursing facility such as a nursing home?**

**A nursing home is a permanent residence for people in need of 24/7 care, while a skilled nursing facility (NSF) is a temporary residence for patients undergoing medically necessary rehabilitation treatment. (Long form not required. ALERT: If yes, bill SNF not Medicare)**

**_____No** **_____ Yes**

**I confirm that the above information is correct.**

**Patient Signature:_____ Print Name:_____Date: _____**