Medicare Secondary Payor
(MSP) Questionnaire – Page 1

PSS Name: _____
Facility Phone: _____
Person Contacted @ HHA:
Name: _____ Phone: _____
Discharged? Y N Discharge Date: _____

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office use only

Patient Name: _____ **Clinic Name:**
Medicare Number: _____ **Patient Acct#:**
(exactly as appears- Red-White-Blue Government Medicare Card) **Database:**

1. **Have you received Home Health Care of any kind in the past 60 days or currently are residing in a Skilled Nursing Facility? ..... Yes No**
   Agency Name/Facility Name: _____
   Phone: _____
   If in a Skilled Nursing Facility: **Are you on/in the "Medicare Unit"?** Yes No

2. **Are you entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program? ..... Yes No**
   If yes, Program Name:_____ Phone: _____
   Address, City, State, ZIP:
   _____
   NOTE: *The government program listed in question #2 will be primary to Medicare.*

3. **Was this injury/illness due to any of the following?**
   Work-related? **If yes**, date of accident/injury: _____ /_____ /_____..... **Yes No**
   Auto accident? **If yes**, date of accident: _____ /_____ /_____ ..... **Yes No**
   Accident on Property? (other than your own)(Example: store, restaurant, etc.) ..... **Yes No**
   If yes, date of accident: _____ /_____ /_____
   If yes, please give details of the accident:

   If yes, please provide the following information about the **liability insurance**:
   Insurance Name:_____ Phone: _____
   Address, City, State, ZIP:
   _____
   Contact Person/Adjustor's Name: _____
   Claim Number: _____ (**required**)
   NOTE: *Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare. Your understanding and cooperation is appreciated.*

4. **Do you feel you have a right to be compensated by a party who may have caused the injury or illness?** ..... **Yes No**
   If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness? ..... Yes No
   If yes, Attorney's Name: _____
   Law Firm Name: _____
   Address: _____
   Phone number: _____

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Medicare Secondary Payor (MSP) Questionnaire – Page 2

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office use only

Patient Name: _____ **Clinic Name:**

Medicare Number: _____ **Patient Acct#:**

(exactly as displayed on Red-White-Blue Government Medicare Card) **Database:**

5. Have you received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD)? ..... Yes No

If yes, please provide the date of the transplant or start of dialysis: ____/____/____

If the date is less than 30 months ago: **Are you currently covered under group insurance provided by your or a family member's employer?** Yes No

If yes – the group insurance will be primary **If no** – Medicare will be primary

6. Are you currently employed? ..... **Yes No**

If yes, Does your employer employ more than 20 employees? ..... Yes No

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

Is your spouse currently employed? ..... **Yes No**

If yes, Does his/her employer employ more than 20 employees?..... Yes No

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

(NOTE: If both are not currently employed, then Medicare is primary.)

7. If you've answered No to questions 1 – 6 AND your Medicare coverage is due to age or disability:

Do you have a group insurance plan through another family member's current employer? ..... Yes No

If yes – the group insurance will be primary **If no** – Medicare will be primary

Do you have any benefits through TriCare (formerly Champus)? ..... **Yes No**

8. If you answered YES to questions 6 or 7, please complete the following group insurance information for the proper billing of your account:

Insurance Co. Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Employer Name: _____

Insured's Name: _____

Policy Identification Number: _____ *(Sometimes referred to as the health insurance benefit package number.)*

Group Identification Number: _____

Patient signature Date

Appointed Representative signature Relationship

(Page 2 of 2 – END OF QUESTIONNAIRE)

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