The Physician Network

Antelope Creek Family Physicians

2200 South 40th Street, Suite 104
Lincoln, NE 68506
Phone: 402.483.6000
Fax: 402.483.6106

Medicare Secondary - Payer Questionnaire

(To be completed for ALL Medicare patients)

Name: ______________________________ Medicare # ____________________

Is the patient a veteran? ______ Date: ______________

	Yes	No
1. Did the VA refer you here for treatment?	____	____
2. Does the patient have a VA “Fee Basis ID card?”	____	____
3. Do you have a “Federal Black Lung” card?	____	____
4. Is the patient covered by an employer’s health insurance plan through their own employment or that of a family member? (Not retiree coverage.)	____	____
5. Is your Medicare entitlement based on End Stage Renal Disease?	____	____
6. Are these services paid by a government research program?	____	____

If you answered “yes” to any of the above questions, please answer the following questions:

a. Does the patient authorize you to bill the VA?	____	____
b. Are the services you are receiving today related to lung disease?	____	____

If the answer is “yes,” submit claims to:

Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828

7. Is this medical condition due to an accident of any kind?

If yes, was it:

Work Related ________ Auto _________ Injured in own home __________

Other ____

If you answered yes to question 7 above, please complete the Medicare Payer form.

For Office Use Only:

Date:	Initials of Associate who reviewed questions with patient	Changes to Questionnaire Yes	No

Automobile, No-Fault or Liability Insurance Information

Date of Accident (mm/dd/yyyy) ____________________

❒ If other than auto, describe accident: ____________________

Name of Business or Property Owner: ____________________

Telephone#: __________ Address: ____________________

Type of Insurance: ❒ Premises Medical ❒ Liability

Are you or a family member going to file a liability claim in connection with this injury? ❒ Yes ❒ No

Complete section below if an Auto, Premises Medical, or Liability Claim will be filed.

Name of Policyholder ____________________

Address of Policyholder ____________________

Policy Number or Claim Identification Number ____________________

Name of Insurance Company ____________________

Address of Insurance Company ____________________

Name of Patient's Legal Representative for this case (if any) ____________________

Phone number of Legal Representative ____________________

Group Health Plan Information (Patient's Own Coverage)

Insurance Company ____________________

Policy Number ____________________ Claim Number ____________________

Insurance Plan Name ____________________

Plan Identification Number ____________________

Employed ❒ Full Time ❒ Part Time

Employer Name ____________________

Employer Address ____________________

City ____________________ State __________ Zip __________

Does employer have more than 20 employees? ❒ Yes ❒ No
More than 100? ❒ Yes ❒ No

Employer Identification Number ____________________

Group Health Plan Information (Coverage through Spouse or other family member's insurance)

Insured's Name ____________________ Relationship to Patient __________

Insurance Company ____________________

Plan Identification Number ____________________

Employed ❒ Full Time ❒ Part Time

Employer Name ____________________

Employer Address ____________________

City ____________________ State __________ Zip __________

Does employer have more than 20 employees? ❒ Yes ❒ No
More than 100? ❒ Yes ❒ No

Employer Identification Number ____________________