

## 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.) | _____ | _____ |

*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

5. Is this medical condition due to an accident of any kind? \_\_\_\_\_
- If yes, was it:
- Work Related \_\_\_\_\_ Auto \_\_\_\_\_ Injured in own home \_\_\_\_\_
- Other \_\_\_\_\_

***Do not go any further unless you answered "yes" to question 5 above.***

*If you answered yes to question 5 above, please complete the following section.*

### **Worker's Compensation Insurance Information**

Date of Accident \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Identification Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Name of Person or Company Insured \_\_\_\_\_

Insurance Company Claim or Policy Number \_\_\_\_\_

Worker's Compensation Claim Number \_\_\_\_\_

Name of Worker's Compensation Agency where claim was filed \_\_\_\_\_

Address \_\_\_\_\_

Has the case been settled?  Yes Date \_\_\_\_\_  No

Name of Patient's Legal Representative in this case (if any) \_\_\_\_\_

Phone number of Legal Representative \_\_\_\_\_

## Automobile, No-Fault or Liability Insurance Information

Date of Accident \_\_\_\_\_

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 \_\_\_\_\_