MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: _____ Relationship to Patient: _____
Patient Name: _____
HIC Number: _____

Patient Age _____ Patient Sex _____

Basis for Patient Entitlement to Medicare
_____ Age _____ Disability _____ End Stage Renal Disease (ESRD)

Group Health Plan Information

1. Is the patient or patient's spouse currently employed? _____ Yes _____ No
   If No: Retirement date of patient: _____
   Retirement date of spouse: _____

   If *Yes*, continue.
   Is patient or spouse employed? _____
   Are there: _____ 1. Less than 20 employees
   _____ 2. More than 100 employees

   Is employee actively working? _____ Yes _____ No

Insurance Company: _____
Policy Number: _____ Claim Number: _____
Insurance Plan Name: _____
Plan Identification Number: _____
Is the patient employed? _____ Yes _____ No Full Time? _____ Part Time? _____
Employer Name: _____
Employer Address: _____
City _____ State _____ Zip Code _____
Employer Identification Number: _____

Automobile, No Fault or Liability Insurance Information

2. Is the illness/injury due to an accident (auto included)? _____ Yes _____ No
   If *Yes*, continue.
Type of non-work-related accident: _____ Automobile _____ Other (describe) _____
Date of Accident: _____
Insurance Situation: _____ Liable _____ Not Liable
Name of Policy Holder: _____
Address of Policy Holder: _____

Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident?_____ Yes_____ No
   If *Yes*, continue.

Date of Accident: _____
Is the patient working? ___ Yes ___ No ___ Full Time? ___ Part time?_____
Employer Name: _____
Employer Address: _____
City _____ State_____ Zip Code _____
Employer Identification Number: _____
Name of Insurance Company: _____
Name of Person or Company Insured: _____
Insurance Company Claim or Policy Number: _____
Workers Compensation Claim Number: _____
Name of Workers Compensation Agency where claim was filed: _____
Address of Agency: _____
Has the case been settled? _____ Yes _____ Date _____ No
Name of Patient's Legal Representative for the case if any: _____
Phone Number of Legal Representative: _____

Veteran's Administration (VA) Authorization Information

Does the patient have a VA fee service card? _____ Yes ____ No
Has the VA issued a special authorization for these services? _____ Yes ____ No
Does the patient authorize you to bill the VA? _____ Yes ____ No

Black Lung Insurance Information

Is the patient entitled to benefits under the Department of Labor's *Black Lung Program*? _____ Yes ____ No

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? ___ Yes ____ No

_____
Patient Signature Date

_____
Witness Signature Date

Name _____

1	2	3	4	5	6	7	8	9	10

Please rate your pain by circling the appropriate number above where "0" is no pain at all and "10" is unbearable pain or pain that would send you to the ER.

Where is your pain located? _____

What is the frequency of your pain? Please circle one.

Infrequent Frequent Constant

Have you had any falls in the past 6 months? Yes or No

Do you experience dizziness when you stand after sitting or when you sit up after laying down?

Please list all your medications with strength and dosage:

_____

_____

_____

_____

Please list all surgeries with date performed:

			Date:
_____	Hip	Right / Left / Both	_____
_____	Knee	Right / Left / Both	_____
_____	Shoulder	Right / Left / Both	_____
_____	Neck		_____
_____	Back		_____
_____	Other	_____	