Company Name

MEDICARE SECONDARY PAYOR QUESTIONNAIRE (MSP)

Beneficiary Name: _____ DOB: _____

HIC No: _____ Medicare Record No. _____

Start of Care: _____

1. Is the patient covered by Veterans Administration, Black Lung or Worker Compensation? *(Please circle applicable one)*
   ☐ Yes ☐ No

   If yes, give name, address, group #, and phone # of employer/insurance company _____

   _____

   Date of Worker Comp. Accident: _____

2. Was illness due to an injury? ☐ Yes ☐ No

   A. Date of Accident _____

   B. What type of accident caused the illness/injury? If fall, explain in detail _____

   _____

   _____

   C. Is the patient filing or intending to file a liability suit? ☐ Yes ☐ No

   If yes, give name, address, and phone # of attorney: _____

   _____

3. Is the patient employed (Medicare disable beneficiaries under age 65 or Medicare beneficiaries over 65) and covered by a group health plan? ☐ Yes ☐ No

   A. Date of Retirement: _____

   B. Is the patient married? ☐ Yes ☐ No

   C. Is the spouse employed? ☐ Yes ☐ No Spouse's date of retirement _____

   D. Does the spouse have group coverage? ☐ Yes ☐ No

   E. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? ☐ Yes ☐ No

   F. Is patient receiving benefits from a health plan of an employer for whom he/she used to work actively? ☐ Yes ☐ No

   G. If patient is covered by a group health plan, does it qualify as a large group health plan (100 employees or more)?
   ☐ Yes ☐ No

   If you answered yes to either 3, 3D, 3E, 3F, or 3G, give name, address, group # and phone # of employer:

   _____

   _____

   If you answered yes to either 3, 3D, 3E, 3F, or 3G, give name, address, group # and phone # of insurance company handling the group coverage:

   _____

   _____

4. Is the patient entitled to benefits solely on the basis of end stage renal disease? ☐ Yes ☐ No

   A. Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No

Patient Signature: _____ Date: _____