Medicare Secondary Payer Questionnaire
(Short form)

The information contained in this form is used to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving any benefits from the following programs?
   Black Lung  _____yes  _____no
   Veteran Affairs  _____yes  _____no
   Research Grant  _____yes  _____no

2. Was illness/injury caused by a work-related (Workmans Comp) or non-work related (Liability) accident or condition?
   _____YES  _____NO
   If yes, answer the following:
   Non-work related? Complete Part II of long form.

3. Is the patient currently employed?
   _____YES (answer next question)  _____NO
   Do you have any group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   _____OVER (complete long form Part IV)  _____UNDER

4. Is the patient’s spouse currently employed?
   _____YES (answer next question)  _____NO
   Does your spouse have any group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   _____OVER (complete long form Part IV)  _____UNDER

5. Is the patient entitled to Medicare benefits as a result of:
   AGE
   DISABILITY?  _____YES (complete long form Part V)  _____NO
   END STAGE RENAL DISEASE?  _____YES (complete long form Part VI)  _____NO

6. Are you currently a patient in a skilled nursing facility such as a nursing home?
   Long form not required- If yes, bill SNF, not Medicare
   _____YES  _____NO

I confirm that the above information is correct.

Patient Printed Name: __________________________________________ Date: __________________________

Patient Signature: ____________________________________________