UNIVERSITY OF DELAWARE HEALTH

Patient:_____

Date of Birth: _____

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(Liabilty) accident or condition?**
   _____YES _____NO
   If yes, answer the following:
   Work related? Complete Part I of long form.
   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: _____