MEDICARE PAYOR QUESTIONNAIRE

This questionnaire helps identify other payors which may be primary to Medicare. The goal of Medicare secondary payor information gathering and investigation is to identify Medicare secondary payor situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Please answer each question (both sides of page) in sequence and comply with any instructions that follow and answer. If the instructions direct you to go to another question, please go directly to that question.

PATIENT'S NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

1. Are you currently employed?
   _____ Yes
   _____ No Date of retirement:_____
   if No, skip to question 4

2. Does your present or former employer offer health insurance?
   _____ Yes
   _____ No
   if No, skip to question 4

3. Does the employer that sponsors your group health plan employ 20 or more employees?
   _____ Yes
   _____ No
   if Yes: Name and address of your employer:

   Employer's work telephone:
   Patient's work telephone:
   Patient's occupation:
   Name and address of group health plan:

   Policy identification number:
   Group identification number:

4. Do you have group health plan coverage based on your spouse's (or parent's) current or former employer?
   _____ Yes
   _____ No
   if No, skip to question 6

(over)

5. Does the employer that sponsors your spouse's (or parent's) group health plan employ 20 or more employees?
   _____ Yes
   _____ No
   if Yes: Name and address of group health plan:

   Policy identification number:
   Group identification number:
   Name of policyholder:
   Relationship to patient:

6. Was your illness/injury due to a work-related accident/condition?
   _____ Yes Date of injury/illness:_____
   _____ No
   if No, skip to question 7
   if Yes: Name and address of worker's compensation plan:

   Policy or identification number:
   Name and address of your employer:

7. Was your illness/injury due to a non-work related accident?
   _____ Yes Date of accident:_____ State in which accident occurred:_____
   _____ No
   if No, skip to question 9

8. What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-automobile
   if Yes: Name and address of no-fault or liability insurer:

   Insurance claim number:

9. Are you entitled to Medicare based on disability?
   _____ Yes
   _____ No

10. Are you receiving Black Lung benefits?
    _____ Yes Date benefits began:_____
    _____ No

11. Have you received a kidney transplant?
    _____ Yes Date of transplant:_____
    _____ No

12. Have you received maintenance dialysis treatments for End Stage Renal Disease?
    _____ Yes Date dialysis began:_____
    _____ No

13. Are you within the 30-month coordination period for End Stage Renal Disease Medicare benefits?
    _____ Yes
    _____ No