



# MID AMERICA HEART & LUNG SURGEONS

## 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

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