Medicare Secondary Payer Screening Form

If answer **is "no" to all** questions then **Medicare is primary**. If answers are "yes" Medicare is likely secondary and additional information is needed.	Yes	no
1. Is the patient under 65? If **yes** process to question 2, if **no** process to question 3		
2. Patient under 65 years of age and entitled to Medicare due to a Disability A) Disability (Under age 65, non-ESRD) Proceed to # 4 B) Covered by Black Lung: proceed to #7 C) ESRD: Proceed to #8		
3. Are you (the patient) currently employed? If Not what your retirement date:____ ____ ____ **If yes complete section "A" on back**		
4. Is your spouse (the patient's) employed? **If not Spouse's retirement date:____ /____ /____**		
5. Is the Patient covered under a Group Health Plan (GHP) (Either their own or that of another family member)? **If yes complete read and answer the following:** 1. Employees of employers with fewer than 20 employees (full time, part time or leased) unless the plan is part of a multi-employer plan that pays primary benefits for all individuals. 2. Self employed individuals with fewer than 20 employees. 3. Individuals entitled to premium Part A or have Part B only. **The GHP is not primary for these 3 situations.** **----------** **Medicare is tertiary if the patient and spouse are both employed and covered by a GHP. Proceed to back of page and complete section "A"**		
6. Is the condition for which the patient is receiving treatment **due to any automobile accident,** accidental injury or third party liability? (i.e. Work related injury) Note: Please continue if admitting diagnosis is a trauma code. If yes **Please complete section "B" for the automobile/ liability screening on back. Or Section "C" for work related injury.**		
7. Is the illness for which the patient is receiving treatment covered under the Black Lung Program, Government Grant Program or are the services provided or authorized by the Department of Veterans Affairs (DVA)? ☐ If Yes Date Black Lung Effective _____ /_____ /_____ Bill Black Lung only if diagnosis is Black Lung related ☐ If Yes Date Government Grant Program Effective _____ /_____ /_____ Bill Government Grant Program ☐ If Yes Bill the Department of Veterans Affairs (DVA) if services were authorized and the DVA agree to pay		
8. Solely end stage renal disease (ESRD) or **ESRD and Age** – **Date of first Dialysis treatment _ _/_ _/_ _** Did patient begin dialysis less than 33 months ago? **If yes** proceed to section D/E If no **Medicare is primary ESRD and disability** proceed to section E/F		

HIC Number_____ **Patient Name**_____

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[A] Patient is covered under a Group Health Plan:
Employer Information is for:
€ Patient € Spouse € Other:_____
Employer Name:_____
Address:_____
_____
City, State, Zip_____
Insurance company::_____
Policy/Group No.:_____

Insured's Name_____
Address:_____
_____
City, State, Zip_____

[C] Work Related – Worker's compensation is the primary payer.

Please complete the following if a Worker's Compensation claim has been filed.
Injury or illness_____

Name of Carrier_____
Address_____
Employer_____
Case/File Number_____
For A/B & C complete the following:
Description of Accident_____
_____
_____
_____
_____

[D] coordination periods for ESRD
1. Did the coordination period begin 3/96 or after? If yes Medicare is secondary for 30 months
2. Did the coordination period begin 2/96 or before? If yes Medicare is secondary for 18 months.
Date of Kidney transplant /home Dialysis _ _/_ _ /_ _ (3 month waiting period does not apply) If participating in self dialysis training program what is start date _ _/_ _/_ _

[B] Automobile/Medical or any Liability Screening
If Medicare is to be billed Explain accident and why Medicare is still primary:
_____
_____
_____
_____

If Medicare is not payer Please complete:
Date of injury:_____ _____ _____
☐ Automobile (Complete A)
☐ Third Party Liability (Complete B
☐ Premise Medical Coverage (Complete A
☐ Work related (Complete C)

1. Automobile Medical/Premise Medical

(if 3rd party liability also exists complete A and B)
Automobile medical insurance/Premise medical insurance is the primary payer. Bill auto-medical or no-fault insurance first.
Insured's Name_____
Policy Number_____
Insurance Company_____
Address_____
Description of Accident (see box__)

2. Third Party Liability (other than auto/medical, premise medical or work related)
Bill third party payer or Medicare conditionally after 120 days.
Description of Accident (see box__)
Location* If accident occurred at a location other than patient's residence, please provide information even if liability is in question.

Name of responsible party_____
Policy Number_____
Insurance Address_____
Insurance Claim Number_____
Attorney Name_____ Telephone Number_____
Attorney Address_____

[E] Patient entitled to Medicare due to age or disability and ESRD (Dual entitlement)

this is true based on # 7 & D _____ patient initials

Patient signature clinician signature

HIC Number_____ **Patient Name**_____