SKIRBALL HOSPICE
A program of the Los Angeles Jewish Home

Medicare Secondary 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 is 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 servicesprovided 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		

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE **CLINICIAN SIGNATURE**

HIC Number _____ **Patient Name** _____ **Date** _____

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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)

B. 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_____

HIC Number _____ **Patient Name** _____ **Date** _____