MEDICARE SECONDARY PAYER FORM

Patient Name: _____ DOB: _____

1. Are you receiving Black Lung Benefits? **YES** **NO**

2. Are the services to be paid by a government program such as a research grant? **YES** **NO**

3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this facility? **YES** **NO**

4. Was the illness/injury due to a work related accident? **YES** **NO**

5. Was the illness/injury due to a non-work related accident? **YES** **NO**
   If yes name of no-fault insurer and policy owner _____

6. Are you entitled to Medicare based on: **A. Age** **D. Disability** **E. ESRD**

7. Are you currently employed? **YES** **NO**

   If yes name and address of your employer: _____

8. **If retired or disabled, as of what date: _____ MUST BE FILLED IN**

9. Is your spouse currently employed? **YES** **NO** **NEVER**
   If yes name and address of your spouse employer: _____

10. **If spouse is retired, date of retirement: _____MUST BE FILLED IN**

11. Do you have group health plan coverage based on your own, or spouse's current employment? **YES** **NO** If so Name of insurance _____