Medicare Payer Questionnaire

*****Must be filled out for ALL Medicare patients every 90 days*****

1. Are you receiving Black Lung (BL) Benefits? (BL will be the primary payer when related to BL)
   ____Yes, Date benefits began:__________
   ____ No
2. Are the services to be paid by a government research program?
   ____Yes, if yes, government research program will be the primary payer
   ____No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   ____Yes, if yes, the DVA will be the primary payer
   ____No
4. Was the illness/injury due to a work-related accident/condition? (WC will be the primary payer – ensure you get the WC claim number, address and phone number)
   ____Yes – date of injury illness:___________
   ____No
5. Was the illness/injury due to a non-work related accident? (Liability Insurance will be the primary payer – ensure you get the Liability claim Number, address, and phone number)
   ____Yes – Date of accident:___________
   ____No
6. Are you entitled to Medicare based on: (Choose all that apply – can be multiple checks)
   ____Age – (65 years of age or older)
   ____Disability
   ____End-Stage Renal Disease (ESRD) – If within the 30 month coordination period if they have GHP it's primary for 1st 30 days
   A. Have you received a kidney implant?
      ____Yes – Date received implant________
      ____No
   B. Do you receive maintenance dialysis treatment or within 30 months coordination period before Medicare began?
      ____Yes – Date treatment began________
7. Do you have a Medicare Replacement plan, or a Managed Care plan?
   ____Yes ____No (If yes, Medicare would not be billed)
   If yes, name of Insurance and Policy Number_______________________________________

   ____
8. Do you have insurance thru your current employer, spouse, or another family member's current employer?
   ____Yes (please give copy of card to registration – if thru spouse, give spouse name and date of birth)
   ____No
   If yes, does the company that supplies your insurance have more than 20 employees?
   ____Yes (If yes, GHP insurance is primary) ____No

______________________________ ________________

Patient Signature Date

Place patient label here