MEDICARE SECONDARY QUESTIONNAIRE

Patient Name:

Please answer the following questions regarding ANY insurance that you have in addition to your Medicare. (PLEASE ANSWER YES OR NO TO # 1-8)

1. Are you 65 or older and covered by a Group Health Insurance through a CURRENT employer or a spouses CURRENT employer with LESS than 20 employees?

__YES or__NO (if yes, Medicare is primary.)

1a. MORE than 20 employees?

__YES or__NO (if yes, your Medicare is secondary to your Health Insurance)

2. Are you 65 or older and have an employer retirement plan?

__YES or __NO (if yes, your Medicare is primary.)

3. Are you disabled and covered through a Large Group Health plan through your current employment or by a family member's current employment with LESS than 100 employees?

__YES or __NO (if yes, your Medicare is primary.)

3a. MORE than 100 employees?

__YES or __NO (if yes, your Medicare is secondary to your Health Insurance)

4. Are you disabled and covered under a Group Health Plan through retirement with your employer?

__YES or __NO (if yes, your Medicare is primary to your insurance)

5. Are you 65 or older OR disabled and covered by Medicare and COBRA?

__YES or __NO (if yes, your Medicare is primary.)

6. Are you covered under Worker's Compensation/No Fault/Motor Vehicle or Liability for services related to THIS visit today?

__YES or __NO (if yes, your Medicare is secondary to the Worker's Comp No Fault/Liability carrier.)

7. Are you covered by the VA for THIS service today?

__YES or __NO (if yes, we cannot bill medicare, the VA must be billed)

_____ _____

Patient Signature Date