PATIENT NAME_____

MEDICAL RECORD # _____

Medicare Secondary Payer Form

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? **Yes** **No**

2. Is illness covered by the Black Lung Program, Veterans Administration or research program? **Yes** **No**

3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? **Yes** **No**

4. Is patient covered by a large group health plan through either the patient's employer or spouse's current employer and the plan is primary over Medicare? **Yes** **No**

5. Medicare Beneficiary's (Patient) Retirement Date_____

6. Is the patient entitled to Medicare based on Disability? **Yes** **No**

Registrar Notes:

A. If patient responds "no" to questions 1-4, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

_____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employee Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's / Legal Representative's Signature: _____ Date: _____ Time: _____