# Medicare Secondary Payer Questionnaire

**1. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)**
_____No _____ Yes

**2. Are you receiving benefits from any of the following programs?**
Black Lung ____No ____Yes
Research Grant ____No ____Yes
Veteran Affairs ____No ____Yes

**3. Was the illness/injury due to a work related accident/condition?**
_____ No _____ Yes
Date of injury/illness: __________________

**4. Was illness/injury due to a non-work related accident?**
_____ No _____ Yes
Date of accident: ___________________

**What type of accident caused the illness/injury?**
_____ Automobile
_____ Non-automobile

**5. Are you entitled to Medicare based on:**
_____ Age
_____ Disability
_____ End Stage Renal Disease

**6. Are you currently employed?**
_____ No _____ Yes

**7. Is your spouse currently employed?**
_____ No _____ Yes

**8. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?**
_____ No _____ Yes

**9. Does the employer that sponsors your GHP employ 20 or more employees?**
_____ No _____ Yes

**I confirm that the above information is correct.**

**Patient Signature:______________________________ Date___________________**

**Please Print Name:______________________________**

Updated: 1/18/2016