

## MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Physician: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

I AM ENTITLED TO MEDICARE BENEFITS:

NO - RETURN FORM TO THE FRONT DESK

YES - PROCEED TO SECTION I.

### SECTION I

Select the ONE statement that is true for you:

I am over 65 and married... **Proceed to section II**

I am over 65 and not married (includes widowed)... **Proceed to section III**

I am under 65, Disabled and currently employed... **Proceed to section IV**

I am under 65, Disabled and unemployed...

Disability Date: \_\_\_\_\_ **IV Proceed to section**

### SECTION II

Select the one statement that is true for you:

My spouse and I are both fully retired

The date of my retirement: \_\_\_\_\_

The date of my spouse's retirement: \_\_\_\_\_ ...**Proceed to section V**

I work full or part-time (my spouse is retired) for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

My spouse works full or part-time (I am retired) for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

### SECTION III

Select the one statement that is true for you:

I am fully retired...

The date of my retirement: \_\_\_\_\_ ....**Proceed to section V**

I work full or part-time for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

### SECTION IV

Select the one statement that is true for you: (This does not apply to supplemental plans or employer plans offered during retirement.)

I have health care coverage through my employer.  NO  YES

I have health care coverage through someone else.  NO  YES

IF YES, list name of guardian and relationship: \_\_\_\_\_

**Proceed to Section V**



Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**SECTION V**

Is this visit related to an injury due to a fall?

YES - Did the accident occur in...  your home  public location  other

Date of Accident: \_\_\_\_\_

**OR**

Is this visit related to an illness/injury due to an automobile accident?

YES - Date of Accident: \_\_\_\_\_

RETURN TO FRONT DESK AND PRESENT YOUR AUTOMOBILE INSURANCE CARD.

NO **Proceed to Section VI**

**SECTION VI**

Indicate which statements apply to you.

I am entitled to Worker's Compensation for this service.

I am entitled to Black Lung benefits.

I am entitled VA benefits.

I am entitled ESRD benefits.

I am entitled COBRA benefits.

I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please Explain: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

