

PATIENT LABEL HERE

MANDATORY

MEDICARE SECONDARY PAYER QUESTIONNAIRE

<p>1. Are you entitled to benefits under the Black Lung Program, Department of Veterans Affairs (VA), or other government program, such as a research grant?</p> <p><input type="checkbox"/> Yes ~ go to #17 <input type="checkbox"/> No ~ go to #2</p>	<p>9. Are you covered under a group health plan (GHP) through your, or your spouse's, employer?</p> <p><input type="checkbox"/> Yes ~ go to #10 <input type="checkbox"/> No ~ Date of retirement ____/____/____ IF NO, MEDICARE IS PRIMARY PAYER</p>
<p>2. Was illness/injury due to a work related accident covered by a Worker's Compensation plan?</p> <p><input type="checkbox"/> Yes ~ go to #17 <input type="checkbox"/> No ~ go to #3</p>	<p>10. Does the employer have 20 or more employees?</p> <p><input type="checkbox"/> Yes ~ go to #17 <input type="checkbox"/> No ~ MEDICARE IS PRIMARY PAYER</p>
<p>3. Was illness/injury due to a non-work related accident?</p> <p><input type="checkbox"/> Yes ~ go to #4 <input type="checkbox"/> No ~ go to #6</p>	<p>11. Have you received a kidney transplant or currently undergoing kidney dialysis for End Stage Renal Disease (ESRD)?</p> <p><input type="checkbox"/> Yes ~ go to #12 <input type="checkbox"/> No ~ go to #13</p>
<p>4. What type of accident caused illness/injury?</p> <p><input type="checkbox"/> Auto ~ go to #17 <input type="checkbox"/> Non-Auto ~ go to #5</p>	<p>12. Date of transplant or start of dialysis: circle one ____/____/____ If less than 12 months, go to #13 If over 12 months, MEDICARE IS PRIMARY PAYER</p>
<p>5. Was another party responsible for this accident?</p> <p><input type="checkbox"/> Yes ~ go to #17 <input type="checkbox"/> No ~ go to #6</p>	<p>13. Do you have group health (GHP) plan coverage through your, or other family member's, employer?</p> <p><input type="checkbox"/> Yes ~ go to #14 <input type="checkbox"/> No ~ MEDICARE IS PRIMARY PAYER</p>
<p>6. Are you 65 or older?</p> <p><input type="checkbox"/> Yes ~ go to #9 <input type="checkbox"/> No ~ go to #7</p>	<p>14. Are you within the 30-month coordination period?</p> <p><input type="checkbox"/> Yes ~ go to #16 <input type="checkbox"/> No ~ MEDICARE IS PRIMARY PAYER</p>
<p>7. Are you entitled to Medicare benefits based solely on End Stage Renal Disease (ESRD)?</p> <p><input type="checkbox"/> Yes ~ go to #11 <input type="checkbox"/> No ~ go to #8</p>	<p>15. Are you covered under a group health plan (GHP) based on your, or other family member's, employer?</p> <p><input type="checkbox"/> Yes ~ go to #16 <input type="checkbox"/> No ~ Date of retirement ____/____/____ IF NO, MEDICARE IS PRIMARY PAYER</p>
<p>8. Are you a disabled Medicare beneficiary under the age of 65?</p> <p><input type="checkbox"/> Yes ~ go to #15 <input type="checkbox"/> No ~ go to #9</p>	<p>16. Does employer have 100 or more employees?</p> <p><input type="checkbox"/> Yes ~ go to #17 <input type="checkbox"/> No ~ MEDICARE IS PRIMARY PAYER</p>

17. MEDICARE IS SECONDARY TO THE BELOW NAMED INSURER Name and address of: (Circle appropriate item)

#1 - BL - Black Lung is PRIMARY only for claims related to Black Lung. If this claim is NOT related to Black Lung, go back to Question #2 and continue.

#1 - VA or Gov't program

#10 - GHP

For #10, 14, 16 Name of Employer:

#2 - Worker's Comp

#14 - GHP

#4 - Auto Insurance

#16 - GHP

#5 - Liability Insurance

Insurance Company, or program, being billed: _____

Address: _____ Policy or other ID # _____

_____ Date of injury/illness: _____

Phone Number: (____) _____ Contact/Adjuster: _____

Date / Patient Signature

Date / HealthSouth Representative Signature