Northeast Georgia DiagnosticClinic Since 1953

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. **Are you receiving benefits from any of the following programs?**

   Black Lung ☐ YES (Long form Part I) ☐ NO
   Research Grant ☐ YES (Long form Part I) ☐ NO
   Veteran Affairs ☐ YES (Long form Part I) ☐ NO

2. **Was illness/injury due to a work related accident/condition?**

   ☐ YES ☐ NO

   If **YES,** answer the following:
   ☐ Work related accident (complete Part I of long form).
   ☐ Non-work related accident (complete Part II of long form).

3. **Is the patient currently employed?**

   ☐ YES (answer next question) ☐ NO

   Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

4. **Is the patient's spouse currently employed?**

   ☐ YES (answer next question) ☐ NO

   Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

5. **Is the patient entitled to Medicare benefits as a result of:**

   Age _____

   End Stage Renal (Kidney) Disease? ☐ YES (Long form part VI) ☐ NO

   Disability? ☐ YES (Long form part V) ☐ NO

6. **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)**

   ☐ YES ☐ NO

   I confirm that the above information if correct.

   Patient Name: _____ Date: _____

   Patient Signature: _____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf