Ohio Hills Health Services
Medicare Secondary Payer Questionnaire
(Short Form)

Patient Name: _____ Date of Service: _____

The information contained in this form is used for Medicare to determine if there is another insurance that should pay as primary to Medicare.

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

   Black Lung ☐ YES ☐ NO
   Research Grant ☐ YES ☐ NO
   Veteran Affairs ☐ YES ☐ NO

   *If "**YES**" is answered will need to fill out long form.*

2. **Is this visit today due to illness/injury due to a work related accident/condition?** ☐ YES ☐ NO
   *If "**YES**" is answered will need to fill out long form.*

3. **Is this visit today due to illness/injury due to a non-work related accident?** ☐ YES ☐ NO
   *If "**YES**" is answered will need to fill out long form.*

4. **Are you entitled to Medicare based on:**

   ☐ Age ☐ Disability ☐ End-Stage Renal Disease (ESRD)

5. **Is the patient and/or spouse currently employed?** ☐ YES (answer next question) ☐ NO

   Do you have a group health plan (GHP)? ☐ YES (answer next question) ☐ NO

   *If "**YES**" is answered and **ESRD** is marked will need to fill out long form.*

A. If you are entitled to Medicare by **Age**, are there 20 or more employees? ☐ YES ☐ NO

B. If you are entitled to Medicare by **Disability**, are there 100 or more employees? ☐ YES ☐ NO

*If "**YES**" is answered for **A** or **B** will need to fill out long form.*

Patient /Representative Signature _____

Date _____

Relationship (if other than patient) _____