**Ohio Hills Health Services**
**Medicare Secondary Payer Questionnaire**
(Long Form)

Patient Name: _____ Date of Service: _____

Medicare Number: _____

## PART I

**1**. Are you receiving Black Lung (BL) Benefits? ☐ YES ☐ NO

If Yes: Date benefits began: MM/DD/CCYY _____

**BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.**

**2**. Are the services to be paid by a government research program? ☐ YES ☐ NO

**IF YES, GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.**

**3**. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

☐ YES ☐ NO IF YES, **DVA IS PRIMARY FOR THESE SERVICES.**

**4**. Is this visit today due to illness/injury due to a work-related accident/condition?

☐ YES: Date of injury/illness: MM/DD/CCYY_____ ☐ NO: **GO TO PART II**

Name and address of workers' compensation plan (WC) plan: _____

_____

_____

_____

Policy or identification number: _____

Name and address of your employer: _____

_____

_____

_____

**WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.**

## PART II

**1**. Is this visit today due to illness/injury due to a non-work-related accident?

☐ YES: Date of accident: MM/DD/CCYY_____ ☐ NO: **GO TO PART III**

**2**. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

☐ YES ☐ NO

Name and address of no-fault insurer(s) and no-fault insurance policy owner: _____

_____

_____

_____

Insurance claim number(s): _____

**3**. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

☐ YES ☐ NO

Name and address of liability insurer(s) and responsible party: _____

_____

_____

_____

Insurance claim number(s): _____

**NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABLITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.**

## PART III

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

- ☐ Age. **Go to PART IV.**
- ☐ Disability. **Go to PART V.**
- ☐ End-Stage Renal Disease (ESRD). **Go to PART VI.**

**Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.**

## PART IV – AGE

**1**. Are you currently employed?

☐ YES ☐ NO If applicable, date of retirement MM/DD/CCYY_____

Name and address of your employer: _____

_____

_____

_____

**2**. Do you have a spouse who is currently employed?

☐ YES ☐ NO If applicable, date of retirement MM/DD/CCYY _____

Name and address of your spouse's employer: _____

_____

_____

_____

**IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.**

**3**. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ YES, Both. ☐ YES, Self. ☐ YES, Spouse.

☐ NO: **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

**4**. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

☐ YES: **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** ☐ NO

Name and address of GHP: _____

_____

_____

_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Name of policyholder/named insured: _____

Relationship to patient: _____

**5**. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 20 or more employees?

☐ YES: **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** ☐ NO

Name and address of GHP: _____

_____

_____

_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Name of policyholder/named insured: _____

Relationship to patient: _____

**IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

## PART V – DISABILITY

**1**. Are you currently employed?

☐ YES ☐ NO If applicable, date of retirement MM/DD/CCYY_____

Name and address of your employer: _____

_____

_____

_____

**2**. Do you have a spouse who is currently employed?

☐ YES ☐ NO If applicable, date of retirement MM/DD/CCYY_____

Name and address of your spouse's employer: _____

_____

_____

_____

**3**. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ YES, Both. ☐ YES, Self. ☐ YES, Spouse. ☐ NO

**4**. Are you covered under the GHP of a family member other than your spouse? ☐ YES ☐ NO

Name and address of your family member's employer: _____

_____

_____

_____

**IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR 11.**

**5**. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

☐ YES: GHP IS PRIMARY. **OBTAIN THE FOLLOWING INFORMATION.** ☐ NO

Name and address of GHP: _____

_____

_____

_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Name of policyholder/named insured: _____

Relationship to patient: _____

**6**. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 100 or more employees?

☐ YES: **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** ☐ NO

Name and address of GHP: _____

_____

_____

_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Name of policyholder/named insured: _____

Relationship to patient: _____

**7**. If you have GHP coverage based on a family member's current employment, does your family member's employer that sponsors or contributes to the GHP, employ 100 or more employees?

☐ Yes: **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** ☐ NO

Name and address of GHP: _____

_____

_____

_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number): _____
Group identification number: _____
Name of policyholder/named insured: _____
Relationship to patient: _____

**IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

## PART VI – ESRD

**1**. Do you have group health plan (GHP) coverage? ☐ YES ☐ NO: **STOP. MEDICARE IS PRIMARY.**

**IF APPICABLE, YOUR GHP INFORMATION:**

Name and address of GHP: _____
_____
_____
_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage: _____
_____
_____
_____

**IF APPICABLE, YOUR SPOUSE'S GHP INFORMATION:**

Name and address of GHP: _____
_____
_____
_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your spouse receives GHP coverage: _____
_____
_____
_____

**IF APPICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:**

Name and address of GHP: _____
_____
_____
_____

Policy identification/Membership number (this number is sometimes referred to as the health insurance benefit package number: _____
Group identification number: _____
Name of policyholder /named insured: _____
Relationship to patient: _____
Name and address of employer, if any, from which your family member receives GHP coverage:
_____
_____
_____
_____

**2**. Have you received a kidney transplant?

☐ YES: Date of transplant: MM/DD/CCYY_____ ☐ NO

**3**. Have you received maintenance dialysis treatments?

☐ YES: Date dialysis began: MM/DD/CCYY_____ ☐ NO

If you participated in a self-dialysis training program, provide date training started: MM/DD/CCYY _____

**4**. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

☐ YES ☐ NO: **STOP. MEDICARE IS PRIMARY.**

**5**. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

☐ YES ☐ NO

**6**. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

☐ YES: **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30- MONTH COORDINATION PERIOD.**

☐ NO: **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

**7**. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

☐ YES: **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

☐ NO: **MEDICARE CONTINUES TO PAY PRIMARY.**

Patient/Representative Signature _____

Date _____

Relationship (if other than patient) _____