

**ZALE LIPSHY UNIVERSITY HOSPITAL  
MEDICARE SECONDARY PAYOR QUESTIONNAIRE**

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

- 1) Is the patient receiving Black Lung benefits? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the date benefits began and the address where the claim should be sent.
- 2) Are the services to be paid by a government program such as a research grant? Yes\_\_\_ No\_\_\_
- 3) Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the address where the claim should be sent.
- 4) Is this illness/injury due to a work-related accident/condition? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the employer name and address, date and type of injury, claim number, and name and address of the worker's compensation plan.
- 5) Is this illness/injury due to a non-work related accident or was another party responsible for an accident that caused this illness/injury? If yes, record in #10 date and type of accident that caused this illness/injury, the name and address of the liability insurer responsible for coverage, and the claim number. Yes\_\_\_ No\_\_\_
- 6) AGE
  - a. Is the patient entitled to Medicare based on age (65 or older)? Yes\_\_\_ No\_\_\_  
If no, move to #7. If yes, complete 6.b. and c. below.
  - b. Is the patient or patient's spouse currently employed by an employer of 20 or more employees? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the employer name and address.  
If no and either the patient or his/her spouse is retired, enter date of retirement in #10 below.
  - c. Does the patient have Group Health Plan coverage based on the patient's or spouse's current employment? Yes\_\_\_ No\_\_\_  
If yes, enter the Group Health Plan data in #10 below. If no, move to Prior Stay Information.
- 7) DISABILITY
  - a. Is this patient entitled to Medicare coverage on the basis of a disability? Yes\_\_\_ No\_\_\_  
If no, move to #8. If yes, complete 7 b. through d. below.
  - b. Is this patient or the patient's spouse or parent actively employed? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the employer name and address.  
If no and either the patient or his/her spouse is retired, enter date of retirement in #10 below.
  - c. Does the patient have Group Health Plan coverage based on his own or a family member's current employment? Yes\_\_\_ No\_\_\_
  - d. Does the employer that sponsors the Group Health Plan employ 100 or more employees? Yes\_\_\_ No\_\_\_  
If yes, enter the Group Health Plan data in #10. If no, move to Prior Stay Information.
- 8) END STAGE RENAL DISEASE
  - a. Is this patient entitled to Medicare coverage on the basis of End Stage Renal Disease (ESRD)? Yes\_\_\_ No\_\_\_  
If no, move to Prior Stay Information. If yes, complete 8 b. through f. below.
  - b. Does the patient have Group Health Plan coverage? Yes\_\_\_ No\_\_\_  
If yes, enter the Group Health Plan data in #10 & answer c. below. If no, move to 8 d. below.
  - c. Has this patient completed the ESRD 30-month coordination period? Yes\_\_\_ No\_\_\_
  - d. Have you received a kidney transplant? Yes\_\_\_ No\_\_\_  
If yes, enter the date of transplant in #10 below.
  - e. Have you received maintenance dialysis treatments? Yes\_\_\_ No\_\_\_  
If yes, enter the date dialysis began in #10 below.
  - f. If you participated in a self-dialysis training program, provide date training started in #10 below.
- 9) Is the patient a member of a Health Maintenance Organization (HMO)? Yes\_\_\_ No\_\_\_  
If yes, record in #10 the HMO name, address, and policy information.
- 10) Name of Insurance Company or HMO \_\_\_\_\_  
Insured's Name and Policy Number \_\_\_\_\_  
Employer / Address \_\_\_\_\_  
Address of Insurance Co. or HMO \_\_\_\_\_  
Date benefits began \_\_\_\_\_  
Date & type of injury/accident, Claim # \_\_\_\_\_

**PRIOR STAY INFORMATION**

Has this patient been confined to a hospital or skilled nursing facility within the last 60 days? Yes\_\_\_ No\_\_\_  
If yes, complete the following information for each stay.

Hospital or SNF _____	Hospital or SNF _____
Address _____	Address _____
Admission Date _____	Admission Date _____
Discharge Date _____	Discharge Date _____
By Whom Verified _____	By Whom Verified _____
Name of person who supplied all of the above information _____	
How is this person related to the patient? _____	
What is this person's telephone number? _____	
Signature _____	Date _____