

Medicare Secondary Payer Form

DATE _____ PATIENT NAME _____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? Yes No
2. Is illness covered by the Black Lung Program or Veterans Administration program? Yes No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? Yes No
- 4a. If under age 65, is your Medicare coverage due to disability? Yes No
- 4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? Yes No
5. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer? Yes No

Registrar Notes:

- A. If patient responds "no" to questions 1-5, Medicare is primary.
- B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employer Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's Signature _____