Medicare Secondary Payer Screening Questionnaire

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

Patient's Name ________________________________ Patient's DOB _______________________

1. Are you covered by the Veterans Administration, the Black Lung Program or Workers Compensation? If so, circle which one. ( ) Yes ( ) No

2. Is this illness or injury due to any type of accident? ( ) Yes ( ) No

3. What is your age? ___________

   a. Are you currently employed? ( ) Yes ( ) No

   b. Have you ever been employed? ( ) Yes ( ) No

   c. Is your spouse currently employed? ( ) Yes ( ) No

   d. Are you covered by any Employer Group Health Plan or any other large Group Health Plan? ( ) Yes ( ) No

4. Do you have End Stage Renal Disease? ( ) Yes ( ) No

   a. Have you received a kidney transplant? ( ) Yes ( ) No

   b. Have you received maintenance dialysis treatment? ( ) Yes ( ) No

   c. If you participated in a self dialysis training program, provide date training started ______________________

5. Why do you receive Medicare? Circle one: Age Disability ESRD

Authorization Statement and Payment Agreement

I declare, under penalty of perjury, that I do not have another primary insurance carrier to pay for medical care rendered to me by MARTIN MEDICAL CENTER, P.C. all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of authorized Medicare Benefits be made to this facility for any services furnished to me by its providers or suppliers.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the provider or supplier agrees to accept the charge determined by the Medicare Carrier as full charge, and the patient is responsible only for the deductible (Excluding UGS/Medicare) coinsurance and non-covered services. Coinsurance and deductible are based upon charge determined by the Medicare carrier.

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Signature of Patient or Authorized Representative Date