AD ASTRA EYE
M. Scott Hickman, MD

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____ Patient # _____

Please read and respond to each of the following:

(Part I)

1. Are you receiving Black Lung Benefits? □ Yes □ No

2. Are the services to be paid by a government research program? □ Yes □ No

3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? □ Yes □ No

(Part II)

4. Is your illness/injury due to any of the following: □ Yes □ No □

Work-Related □ Automobile Accident □ Accident on Property (other than your own)

5. If Medicare coverage is due to age or disability, do you have group insurance coverage through your or another family member's current employer? □ Yes □ No

6. Are you entitled to Medicare due to End Stage Renal Disease and age or ESRD and disability?

□ Yes □ No

7. Do you have any benefits through TriCare (formerly Champus)? □ Yes □ No

If you answered yes to questions **4, 5** or **6** there is a second form to be filled out.

Patient's Signature _____ Date _____

Thank You

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If you answered yes to questions **4** on the MSP Questionnaire the following questions will need to be completed: (Question 4) Was your illness/injury due to any of the following?

□ Work-Related Accident □ Automobile Accident

Date:_____ Date:_____

□ Accident on Property (other than your own) Accident Date: _____

Please give details of the accident: _____

(Part III)

1. Do you intend to file a liability claim or lawsuit in connection with this injury or illness?

□ Yes □ No Please provide the name, address and contact information of the liability insurance:

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

Contact: _____

Claim Number: _____

Note: Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare.

We appreciate your cooperation.

If you answered yes to questions **5 or 6** on the MSP Questionnaire the following questions will need to be completed:

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(Question 5)

1. Are you currently employed? □ Yes □ No If applicable, date of retirement: _____

2. Do you have a spouse who is currently employed? □ Yes □ No

3. I have GHP coverage based on:

□ My own □ My spouse's employment

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____ Employer: _____

Insured's

Name: _____

Subscriber ID# : _____

Group number: _____

(Question 6) 1. Have you received a kidney transplant? □ Yes □ No

If yes, date of transplant: _____

2. Have you received maintenance dialysis treatments? □ Yes □ No

Date dialysis began: _____

3. Have you participated in a self-dialysis training program? □ Yes □ No

Date training started:_____

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

Patient signature: _____ Date _____

Thank you for your cooperation!