Medicare Secondary Payer (MSP) Questionnaire

_____ _____

Patient Name – Please print **Date of Birth**

PART I

1. Are you receiving Black Lung (BL) Benefits?
   ___ **Yes** Date benefits began: _____/_____/_____
   BL is Primary payer only for claims related to BL.
   ___ **No**

2. Are the services to be paid by a government research program?
   ___**Yes** **Government research program will pay primary benefits for these services**.

   ___ **No**

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

   ___ **No**

4. Was the illness/injury due to a work-related accident/condition?
   ___**Yes** Date of injury/illness: _____/_____/_____
   Name and address of workers' compensation (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.

   ___ **No** Go to part II

PART II

1. Was illness/injury due to a non-work-related accident?
   ___ **Yes** Date of accident: _____/_____/_____

   ___ **No** Go to part III

2. Is no-fault insurance available? (No –fault insurance is insurance that pays health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
   ___ **Yes** Name and address of no-fault insurer(s) and no-fault insurance policy owner:
   _____
   _____
   Insurance claim number(s): _____
   ___**No**

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** Name and address of liability insurer(s) and responsibility party:
   _____
   _____
   Insurance claim number(s): _____
   ___ **No**
   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 liability 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** Name and address of your employer: _____
   _____
   ___**No** If applicable, date of retirement: _____/_____/_____
   ___**No** Never Employed.

2. Do you have a spouse who is currently employed?
   ___**Yes** Name and address of the employer: _____
   _____
   ___**No** If applicable, date of retirement: _____/_____/_____
   ___**No** Never Employed.

   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 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**.
   Name and address of GHP: _____
   _____
   Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____
   Group identification number: _____
   Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):_____
   Name of policyholder/name insured: _____
   Relationship to patient: _____
   ___ **No**

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

___**Yes** **GHP is Primary. Obtain the following information.**

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

___ **No** **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** Name and address of your employer: _____

_____

___**No** If applicable, date of retirement: _____/_____/_____

___ **No** Never Employed.

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

___ **Yes** Name and address of your employer: _____

_____

___**No** If applicable, date of retirement: _____/_____/_____

___ **No** Never Employed.

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 Name and address of family member's employer: _____

_____

___No **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 II.**

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

___Yes **GHP is Primary. Obtain the following information.**

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

___ No **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.**

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**.

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

___**No**

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.**

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

___ **No** **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 **If applicable, your GHP information:**

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

If applicable, your spouse's GHP information:

Name and address of GHP: _____

_____

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

Group identification number: _____

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):

_____

Name of policyholder/name insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

If applicable, your family member's GHP information:
Name and address of GHP: _____

_____

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

Membership number *(prior to the Health Insurance Portability and Accountability act [HIPAA], this number was frequently the individual's Social Security Number [SSN]; it is the unique identifier assigned to the policyholder/patient*):
_____

Name of policyholder/name insured: _____

Relationship to patient: _____
Name and address of employer, if any, from which your family member receives GHP coverage: _____

_____

___No **STOP. Medicare is Primary**

2. Have you received a kidney transplant?
___**Yes** Date of Transplant: _____/_____/_____
___**No**

3. Have you received maintenance dialysis treatments?
___ **Yes** Date dialysis began: _____/_____/_____
If you participated in a self-dialysis training program, provide date training started: _____/_____/_____
___**No**

4. Are you within the 30-month coordination period that starts _____/_____/_____?

(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 of kidney transplant.)

___ **Yes**

___**No** **STOP. Medicare is Primary.**

Patient Name – Please print | **Date of Birth**

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 Signature	Date Completed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed

MEDICARE SECONDARY PAYER (MSP)
QUESTIONNAIRE SIGNATURE PAGE

Patient Name – Please print	Date of Birth

Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed
Patient Signature	Date Reviewed