Limp In, Leap Out

Mid-Michigan Physical Therapy Specialists

Formerly: Fowlerville PT Specialists

Limp In, Leap Out

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MEDICARE SECONDARY PAYER QUESTIONAIRE

Person Giving Information: _____

Relationship to Patient:_____

Patient Name: _____ Patient Account #: _____

Medicare Number: _____

PART I

1. Are you receiving BLACK LUNG benefits? **( ) Yes ( ) No**

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

4. Was the illness/injury due to a work related accident/condition? **( ) Yes ( ) No if NO; go to Part II**
   If yes; Date of injury/illness _____
   Name and address of WC plan: _____
   Policy or identification number: _____

PART II

1. Was illness/injury due to a non-work related accident? **( ) Yes ( ) No If NO; go to part III**
   Yes; date of Accident: _____

2. What type of accident caused the illness/injury?

   _____ Automobile _____ Non Automobile _____ Other

   Name and address of no-fault or liability insurer: _____
   _____

   Insurance claim # _____

3. Was another party responsible for this accident? ( ) Yes

   Name and address of liability insurer: _____
   Insurance Claim # _____

PART III

1. Are you entitled to Medicare based on:

_____ Age **(Go to part IV)** _____ Disability **(Go to part V)**

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_____ ESRD (End Stage Renal Disease) **(Go to part VI)**

PART IV – AGE

1. Are you currently employed? **( ) Yes ( ) No** if No; Date of Retirement _____
   Or ( ) No Never Employed

   If yes; Name and address of employer: _____

   _____

2. Is your spouse currently employed? **( ) Yes ( ) No** if No; Date of Retirement _____
   Or ( ) No Never Employed

   If yes; Name and address of spouse's employer: _____

   _____

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? **( ) Yes ( ) No**

4. Does the employer that sponsors your GHP employee 20 or more employees? **( ) Yes ( ) No**

   If yes; Name and Address of GHP: _____

   _____

   Policy number: _____ Group number: _____

   Name of Policy Holder: _____ Relationship: _____

PART V - DISABILITY

1. Are you currently employed? **( ) Yes ( ) No** if No; Date of Retirement _____
   Or ( ) No Never Employed

2. If married, is your spouse currently employed? **( ) Yes ( ) No** if No; Date of Retirement _____
   Or ( ) No Never Employed

   If yes; Name and address of spouse's employer: _____

   _____

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment? **( ) Yes ( ) No**

4. Are you covered under the group health plan of a family member other than your spouse? **( ) Yes ( ) No**
   If yes; Name and Address of your family member's employer _____

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_____

5. Does the employer that sponsors the GHP employ 100 or more employees? **( ) Yes ( ) No**
   If yes; Name and address of GHP: _____

   _____

   Policy number: _____ Group number: _____

   Name of Policy Holder: _____ Relationship: _____

PART VI – ESRD

1. Do you have group health plan (GHP) coverage? **( ) Yes ( ) No**
   If yes; Name and address of GHP: _____
   _____

   Policy number: _____ Group number: _____

   Name of Policy Holder: _____ Relationship: _____

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

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

   If yes; date of transplant _____

3. Have you received maintenance dialysis treatments? **( ) Yes ( ) No**

   If yes; date dialysis began: _____

If you participated in a self-dialysis training program, provide date training started: _____

4. Are you within the 30-month coordination period : Date _____

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 and dual entitlement based on ESRD?
   ( ) Yes ( ) No

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement? **( ) Yes ( ) No**

_____ _____

Patient Signature Date Witness Signature Date

Patient Name: Acct. #