



**IF YOU HAVE MEDICARE, PLEASE FILL OUT THE FOLLOWING
MEDICARE SECONDARY PAYER QUESTIONNAIRE**

Patient _____ Date _____

CIRCLE ONE

Is this illness/injury covered by Workman’s Compensation? **Y N**

If yes please list employer’s or insurer’s name and address along with claim number below.

Is this illness/injury covered under the **Federal Black Lung** program? **Y N**

If yes the bill should be sent to:

Federal Black Lung Program
PO Box 898
Lanham-Seabrook, MA 23073

Is this illness/injury the result of an auto accident? **Y N**

If yes please enter the responsible auto insurer information below.

Is this patient covered by any employer group health plan?
(This includes any Federal Employee Health Benefits) **Y N**

If no Medicare is primary

If yes have you completed the ESRD coordination period? **Y N**

Is the patient or patient’s spouse actively employed by an employer that has

20 or more employees? **Y** **N**
If yes please enter the employer's group health plan date _____

If no Medicare is primary.

Is the patient under age 65 and entitled to Medicare due to a disability? **Y** **N**

Is the patient entitled to Medicare solely on the basis of ESRD? **Y** **N**

If no Medicare is primary

Has the patient completed the ESRD coordination period? **Y** **N**
If no please enter the employee group health date. _____

If yes Medicare is primary.

Employer _____

Name of Insurance Company _____

Address to send claims

Name of policy holder _____

Policy holder's date of birth _____

Policy Number _____