

Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date
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Patient's Name	Account No.	Medicare No.
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You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

<p>Does the patient have an HMO policy? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of HMO: _____ _____</p> <p>Does the HMO replace Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If Yes, the HMO will be primary. If No, it will be secondary.</i></p> <p>Is this patient an inpatient? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Was the patient given Important Message? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><i>If No, why not?</i> _____</p>	<p>Has patient been an Inpatient in a health care facility within the last 60 days? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of facility: _____ _____</p> <p>Has the patient had any outpatient medical services in the last 72 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of facility: _____ _____</p>
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<p>1. Are you receiving Black Lung (BL) Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date benefits began: _____ <i>If Yes, BL is Primary only for claims related to BL.</i></p> <p>2. Are the services to be paid by a government program such as a research grant? <input type="checkbox"/> No <input type="checkbox"/> Yes; <i>Government program will pay primary benefits for these services.</i></p> <p>3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? <input type="checkbox"/> No <input type="checkbox"/> Yes; <i>DVA is primary for these services.</i></p> <p>4. Was the illness/injury due to work related accident or condition? <input type="checkbox"/> No; Go to Question 5. <input type="checkbox"/> Yes; Date of injury/illness: _____ Name, address and phone of Workers Compensation Plan: _____ _____ Policy or ID Number: _____ Name, address and phone number of your employer: _____ _____ <i>If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. Go to Question 8.</i></p> <p>5. Was the illness/injury due to a non-work related accident? <input type="checkbox"/> No; Go to Question 8. <input type="checkbox"/> Yes; Date of accident: _____</p> <p>6. What type of accident caused the illness/injury? <input type="checkbox"/> Automobile <input type="checkbox"/> Non-Automobile Name, address and phone of no-fault or liability insurer: _____ _____ Insurance Claim Number: _____ <i>No-Fault insurer is Primary payor only for those claims related to the accident. Go to Question 8.</i> <input type="checkbox"/> Other (explain) _____</p>	<p>7. Was another party responsible for this accident? <input type="checkbox"/> No; Go to Question 8. <input type="checkbox"/> Yes; Provide name, address and phone of any liability insurer: _____ _____ Insurance claim number: _____ <i>If yes, liability insurer is Primary only for those claims related to the accident. Go to Question 8.</i></p> <p>8. Are you entitled to Medicare based on: <input type="checkbox"/> Age; Go to Questions 9 – 12. <input type="checkbox"/> Disability; Go to Questions 13 – 16. <input type="checkbox"/> ESRD; Go to Questions 17 – 23.</p> <p>9. Are you currently employed? <input type="checkbox"/> No; Date of retirement: _____ <input type="checkbox"/> Yes; Provide name, address and phone of your employer: _____ _____</p> <p>10. Is your spouse currently employed? <input type="checkbox"/> No; Date of retirement: _____ <input type="checkbox"/> Yes; Provide name, address and phone of spouse's employer: _____ _____ <i>If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer. Do not proceed any further. If yes to questions 9 or 10, go to questions 11 and 12.</i></p> <p>11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? <input type="checkbox"/> No; Stop. Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7. <input type="checkbox"/> Yes</p>
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Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

Medicare Secondary Payor Development Form

Patient's Name _____	Account No. _____	Medicare No. _____
12. Does the employer that sponsors your GHP employ 20 or more employees? <input type="checkbox"/> No; Stop. Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7. <input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information. Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	17. Do you have group health plan (GHP) coverage? <input type="checkbox"/> No: Stop. Medicare is Primary. <input type="checkbox"/> Yes; Provide name, address and phone of GHP: _____ _____ Policy ID Number _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____ Name, address and phone of employer, if any from which you received GHP coverage: _____ _____	
13. Are you currently employed? <input type="checkbox"/> No; Date of Retirement _____ <input type="checkbox"/> Yes; Provide name, address and phone of your employer: _____ _____	18. Have you received a kidney transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date of Transplant: _____	
14. Is a family member currently employed? <input type="checkbox"/> No <input type="checkbox"/> Yes; Provide name, address and phone of employer: _____ _____ <i>If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. Do not proceed any further.</i> <i>If Yes to questions 13 or 14, go to question 15 and 16.</i>	19. Have you received maintenance dialysis treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date dialysis began: _____ If you participated in self dialysis training program, provide date training started: _____	
15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment? <input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7. <input type="checkbox"/> Yes	20. Are you within the 30 month coordination period? <input type="checkbox"/> No; Stop. Medicare is Primary. <input type="checkbox"/> Yes	
16. Does the employer that sponsors your GHP, employ 100 or more employees? <input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7. <input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information: Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability? <input type="checkbox"/> No; Stop. GHP is Primary during the 30 month coordination period. <input type="checkbox"/> Yes	
22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD? <input type="checkbox"/> No; <i>Initial entitlement based on age or disability.</i> <input type="checkbox"/> Yes; Stop. GHP continues to pay Primary during the 30th month coordination period.	23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)? <input type="checkbox"/> No; <i>Medicare continues to pay Primary.</i> <input type="checkbox"/> Yes; <i>GHP continues to pay Primary during the 30 month coordination period.</i>	
I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.		
X _____ Patient or Representative / Relationship	X _____ Witness	_____ Date