Cabell Huntington Hospital

Edwards Comprehensive Cancer Center

# Medicare Secondary Payor Questionnaire

BENEFICIARY NAME:_____MEDICARE NUMBER_____

PATIENT ACCOUNT #_____REGISTRAR_____

HAVE YOU HAD OUTPATIENT OR ER SERVICES WITHIN LAST 3 DAYS?_____

HAVE YOU ELECTED HOSPICE COVERAGE?_____

RECEIVING BLACK LUNG BENEFITS?_____DATE BEGAN BLACK LUNG_____

ARE SERVICES COVERED BY GOV'T PROGRAM SUCH AS A RESEARCH GRANT?_____

ARE YOU ELIGIBLE FOR VA BENEFITS?_____

IS THIS VISIT FOR A WORKERS COMP RELATED INJURY/ILLNESS?_____

STATE WORKERS COMP?_____ WHAT STATE?_____

FEDERAL WORKERS COMP?_____

DATE OF INJURY_____CLAIM NUMBER_____

EMPLOYER_____

ADDRESS_____

ILLNESS DUE TO A NON-WORK RELATED ACCIDENT?_____

DATE OF ACCIDENT_____ TYPE_____

NO FAULT INS AVAILABLE?_____

AUTO LIABILITY INS_____

RESPONSIBLE PARTY NAME:_____

ADDRESS_____

INSURANCE COMPANY_____

GROUP NUMBER_____POLICY NUMBER_____

IS THIS RELATED TO A LEGAL SUIT?_____

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ATTORNEY_____

ADDRESS_____

PHONE_____

ARE YOU ENTITLED TO MEDICARE?_____

BASED ON AGE_____ARE YOU ON DISABILITY?_____

DATE LAST WORKED_____

DO YOU HAVE END STAGE RENAL DISEASE?_____

REC'D MAINTENANCE DIALYSIS_____

INITAIL DATE OF DIALYSIS TREATMENT_____KIDNEY TRANSPLANT DATE_____

ARE YOU EMPLOYED?_____NAME OF EMPLOYER_____

ADDRESS_____

***ESTIMATED OR ACTUAL RETIREMENT DATE**_____

IS YOUR SPOUSE EMPLOYED?_____NAME OF EMPLOYER_____

ADDRESS_____

***ESTIMATED OR ACTUAL RETIREMENT DATE**_____

DO YOU HAVE GHP COVERAGE FROM YOUR OWN OR A SPOUSE'S EMPLOYER?_____

COMPANY_____ESTIMATE # TOTAL EMPLOYEES_____

GROUP #_____POLICY #_____

ARE YOU COVERED ON GHP OF A FAMILY MEMBER OTHER THAN SPOUSE?_____

RELATIONSHIP_____COMPANY_____

GROUP #_____POLICY#_____

IS MSP COMPLETE?_____REASON MSP NOT COMPLETE:_____