WellsBrooke
CERTIFIED HOME HEALTH CARE

Medicare Secondary Payer Questionnaire

Federal Law requires completion of this form for all Medicare patients

Name (First, MI, Last): _____

Date of Birth: _____ **Date of Service:** _____

1. Is the patient 65 years or older? □ Yes □ No

2. A. Is the patient currently employed? □ Yes □ No **If No, go on to Question 2D**
   If Yes, current employer name _____
   Employer Address _____ City _____ State ____ Zip _____
   B. Does this employer employ 20 or more employees? □ Yes □ No
   C. Does the patient have an insurance health plan through this current employer? □ Yes □ No
   If Yes: Insurance company name _____
   Insurance address _____ City _____ State ____ Zip _____
   Policy #: _____
   D. If not currently employed: Has the patient ever worked? □ Yes □ No
   If Yes, date last worked: _____

3. Is the patient married? □ Yes □ No **If No, go on to Question 3E**
   A. If Yes, is spouse currently employed? □ Yes □ No
   B. If Yes, spouse's employer name _____
   Employer Address _____ City _____ State ____ Zip _____
   C. Does this employer employ 20 or more employees? □ Yes □No
   D. Is the patient covered by an insurance health plan through this employer? □ Yes □ No
   If Yes, Insurance company name _____
   Subscriber's name _____
   Insurance address _____ City _____ State ____ Zip _____
   Policy # _____
   E. If spouse if not currently employed: Has the spouse ever worked? □ Yes □ No
   If Yes, date last worked: _____

4. A. Is the patient entitled to Medicare solely on the basis of disability other than ESRD? □ Yes □ No
   B. Is the patient covered by an Insurance Group Health Plan through the current employment of someone other than self or spouse? □ Yes □ No
   C. If Yes, employer name _____
   Employer address _____ City _____ State ____ Zip _____
   D. Subscriber name _____ Relationship to patient _____
   Insurance company name _____ Policy # _____
   Insurance address _____ City _____ State ____ Zip _____
   E. If the patient is covered under an insurance plan through the current employer of anyone, including self, does the employer employ 100 or more employees? □ Yes □ No

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(continued)

5. Is the patient entitled to Medicare based on End Stage Renal disease? □ Yes □ No
If No, go on to Question 6

A. Has the patient received self-dialysis training (home dialysis)? □ Yes □ No
If Yes, date started: _____

B. Has the patient received maintenance dialysis (hemodialysis) □ Yes □ No
If Yes, date started: _____

C. Has the patient received a kidney transplant? □ Yes □No If Yes, when: _____

D. Is the patient within the 30-month coordination period? □ Yes □ No

E. Is the patient entitled to Medicare based on ESRD and age or ESRD and disability? □ Yes □ No

F. Was the patient's initial entitlement based on ESRD? □ Yes □ No **If No, go on to Question 5G**

G. Initial entitlement to Medicare was based on age or disability: Is all criteria for working aged/ disability rule present? □ Yes □ No

6. Is today's service related to a Workers Compensation case? □ Yes □ No If Yes, complete Part II

7. Is today's service related to a no Fault (auto accident)? □ Yes □ No If Yes, complete Part II

8. Is today's service related to a liability case in which another party is responsible? □ Yes □ No
If Yes, complete Part II

9. Is any other program responsible for payment of today's services; check any that apply:

□ Black Lung □ Veterans Administration □ Research Grant □ Other

If any other apply, complete Part III

PART II Workers Compensation, No Fault, liability information

Date of accident or injury: _____

Policy #: _____ Insurance name: _____

Insurance address _____ City _____ State ____ Zip _____

If Workers Compensation related:

Employer name: _____

Employer address _____ City _____ State ____ Zip _____

PART III Other program responsible for payment information

If research grant or study, study name: _____

If Veterans Administration, has VA authorized this service? □ Yes □ No

If Black Lung benefits, date these benefits began: _____