Medicare Secondary Payer Form

DATE_____ PATIENT NAME_____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? ☐Yes ☐No

2. Is illness covered by the Black Lung Program or Veterans Administration program? ☐Yes ☐No

3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ☐Yes ☐No

4a. If under age 65, is your Medicare coverage due to disability? ☐Yes ☐No

4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? ☐Yes ☐No

5. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer? ☐Yes ☐No

Registrar Notes:

A. If patient responds "no" to questions 1-5, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

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Name of Policy Holder _____

Policy Number _____

Policy Holder's Employer Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's Signature _____

Form A-1