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MEDICARE SECONDARY PAYER QUESTIONNAIRE

(To be completed for all Medicare patients)

NAME_____

DOB_____

(If any answer to questions 1a through 4 is yes, the corresponding section of "Other Insurance" form must be filled out completely)

	YES	NO
1. Is the patient a Veteran?	___	___
a. Did the VA refer you here for treatment?	___	___
b. Does the patient have a VA "fee basis ID card"?	___	___
2. Do you have a Federal Black Lung Card?	___	___
3. Is this medical condition due to an accident of any kind?	___	___

If yes, was it: Work Related____ Auto____
Injured in own home____ Other____

Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (NOT retiree coverage) ___ ___

SIGNATURE_____

DATE_____