Medicare Primary Payer Questionnaire

The questions listed below are for beneficiaries or older, and is used to comply with Medicare Regulation 42 CFR 489.20(F).

1. Are you currently working full or part time? Yes No

2. If married, is your spouse working full or part time? Yes No

3. Are you currently under any employer group health plan? Yes No
   If Yes, please provide the following information:
   Name of Insured: ____________________________
   Relationship to Patient: ________________________
   Name of Employer: ___________________________
   Name of Insurance Carrier: _____________________
   Group/Policy# _______________________________

4. Are you entitled to Black Lung Benefits? Yes No

5. Is this service for treatment work related? Yes No
   If Yes, please provide the following information:
   Name of Insurer _______________________________
   Name of Employer _____________________________
   Date of Injury _________________________________
   Policy/Claim# _________________________________

6. Is this service for treatment related to an auto injury? Yes No
   Name of Insurer _________________________________
   Name of Policyholder ____________________________
   Date of Injury __________________________________
   Claim# ____

7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Patient Name_________________________________ Date__________________

Patient Signature ____