ABBEVILLE AREA MEDICAL CENTER

Medicare Secondary Payer Questionnaire

20.2.1 - Admission Questions to Ask Medicare Beneficiaries (Rev.)

This questionnaire helps us to meet the Medicare regulations that state: *"Any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. Additionally, 42 CFR 489.20(g) requires that all providers must agree "to bill other primary payers before billing Medicare."*

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: _____ (MM/DD/CCYY) ___ No.

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services ___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes. **DVA IS PRIMARY FOR THESE SERVICES.** ___ No.

4. Was the illness/injury due to a work-related accident/condition?

___ Yes; Date of injury/illness_____ (MM/DD/CCYY) ___ No. **GO TO PART II.**

Name and address of WC plan: _____

Policy or identification number: _____

Name and address of your employer: _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.

Part II

1. Was illness/injury due to a non-work-related accident?

___ Yes; Date of accident: _____ (MM/DD/CCYY) ___ No. **GO TO PART III**

2. What type of accident caused the illness/injury?

___ Automobile. ___ Non-automobile.

Name and address of no-fault or liability insurer: Insurance claim number: _____

_____

_____

_____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?

___ Yes; ___ No. **GO TO PART III**

Name and address of any liability insurer: Insurance claim number: _____

_____

_____

_____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

Part III

1. Are you entitled to Medicare based on:

___ Age. Go to Part IV. ___ Disability. Go to Part V. ___ ESRD. Go to Part VI.

Part IV - Age

1. Are you currently employed?

___ Yes. ___ No. Date of retirement: _____ (MM/DD/CCYY) ___No. Never Employed.

Name and address of your employer:

_____

_____

_____

2. Is your spouse currently employed?

___ Yes. ___No. Date of retirement: _____ (MM/DD/CCYY) ___No. Never Employed.

Name and address of spouse's employer:

_____

_____

_____

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

___ Yes. ___ No. STOP.

MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ Yes. **STOP. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number):
_____ Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):
_____ Name of policyholder/named insured: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed? ___ Yes. ___ No. Date of retirement: _____ (MM/DD/CCYY) ___No. Never Employed.

Name and address of your employer:

_____

_____

_____

2. If married, is your spouse currently employed?

___ Yes. ___ No. Date of retirement: _____ (MM/DD/CCYY) ___No. Never Employed.

Name and address of your spouse's employer:

_____

_____

_____

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

___ Yes.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.**

4. Are you covered under the group health plan of a family member other than your spouse?

_____Yes. _____No.

Name and address of your family member's employer:

_____

_____

_____

5. Does the employer that sponsors the GHP employ 100 or more employees?

___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____ Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

If yes, name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number: _____ Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____ Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: _____ (MM/DD/CCYY) ___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: _____ (MM/DD/CCYY) ___ No

If you participated in a self-dialysis training program, provide date training started: _____ (CCYY/MM/DD)

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

___ Yes ___ No. **STOP. MEDICARE IS PRIMARY**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes. ___ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

_____	_____	_____
Signature of beneficiary	Printed name of beneficiary	Date
_____	□ REVIEWED/ No changes needed	_____
Signature of beneficiary	□ CHANGES NEEDED/ see new form	Date
_____	□ REVIEWED/ No changes needed	_____
Signature of beneficiary	□ CHANGES NEEDED/ see new form	Date
_____	□ REVIEWED/ No changes needed	_____
Signature of beneficiary	□ CHANGES NEEDED/ see new form	Date
_____	□ REVIEWED/ No changes needed	_____
Signature of beneficiary	□ CHANGES NEEDED/ see new form	Date