

MEDICARE
SECONDARY
PAYER

A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Use: Completion required for any situation where another payer or insurer pays your medical bills before Medicare

Patient's Name _____ Date of Birth _____

Medicare Number _____ Date of service _____

We ask that you complete this form with either a "Y" for yes or "N" for No, dates and address required where indicated.

Part I

Government Program Coverage

1. Is the patient receiving Black Lung Benefits? _____
 - a. Date benefits began: _____/_____/_____
2. Are services covered by a government program (research)? _____
3. Has the Department of Veteran's Affairs agreed to pay for Care? _____
4. Was illness due to work related accident/condition? _____
 - a. If Yes, name and address of workers compensation plan:

(Please note: If you answered "yes" to any questions, then that plan is primary to Medicare. If you answered "no" to all, then go to the next section.)

Part II

Accident Related Injuries

1. Was illness/injury due to non-work related accident? _____
If "No", then go to the next section
If "Yes", date: _____/_____/_____
2. Was accident caused by automobile _____, non-automobile _____ or another party? _____
If yes, provide name, address, phone, claim # of no-fault or liability insurer:

Part III

Reasons for Medicare Benefits:

1. Is beneficiary entitled to Medicare benefits based on:
Age: _____
Disability _____: if yes, go to Part V
End Stage Renal Disease: _____, if yes, go to Part VI
2. Is beneficiary part of a Medicare HMO or Medicare Advantage plan? _____
If yes, then the HMO or Advantage plan replaces Medicare

Turn over to complete

