Ability Health Services: MEDICARE SECONDARY PAYOR QUESTIONNAIRE FORM

1. Are you receiving Home Health Care (nursing, therapy)? _____ NO
_____ YES Date began: _____**STOP!**
Patient can not be receiving both, out patient therapies and in home care.

2. HAVE YOU RECEIVED ANY HOME THERAPY??? _____ NO
(*Front Desk-please call to confirm Discharge Date*) _____ YES Location:_____
Date last seen?_____

3. Have you received any therapy in or out of State? _____ NO
_____ YES Location:_____
Date last seen?_____

4. Are services to be paid by a government program such as research grant? ___ Yes; **STOP!**, Government Program will pay primary benefits for these services. ____ NO, Please go to the next question.

5. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
_____ YES **STOP!** Government will pay primary benefits.
_____ NO Please go to the next question

6. Was this due to Illness or Injury due to **WORK** related accident? _____ **NO** Please, go to the next question
_____ YES Date began: _____

Name and address of

The WC plan: _____
Claim# _____ Employer Name and number: _____

7. Was this due to a fall, injury or any other form of an accident?
_____ **YES Date began: _____ Go to question #8 and describe.**
_____ NO Please go to the question #9

8. How and where did the accident happen?

_____
_____
_____
_____

9. Are you entitled to Medicare based on: ____ Age Date of Retirement: _____
____ Disability Date of Disability: _____
____ ESRD

10. Are you currently employed? _____ YES _____ NO

If yes please provide name and number of employer: _____

11. Is spouse employed? _____ NO
(If yes, do you have group health plan coverage, based on your own or spouses current employment)
_____ YES **STOP!** Medicare is not primary, get other Ins. Info.

_____ _____
PATIENT'S SIGNATURE DATE WITNESS SIGNATURE DATE