BROOKS Rehabilitation

Medicare Secondary Payor Form

Patient Name:_____

Account: _____

Please answer ALL questions. ***All dates should be in the following format:*** **CCYY / MM / DD**

PART I:

1. Are you receiving Black Lung (BL) benefits?
   [ ] NO
   [ ] YES - Date benefits began: _____/_____/_____
   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?
   [ ] NO
   [ ] YES – Government will pay primary benefits for these services.
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   [ ] NO
   [ ] YES – DVA is primary for these services.
4. Was the illness/injury due to a work-related accident/condition?
   [ ] NO - Go to Part II
   [ ] YES – Date of injury / illness: _____/_____/_____
   Worker's Comp is primary only for claims related to work-related injuries or illnesses.

   Name and address of Worker's Comp plan:

   _____

   _____

   _____

   Policy or ID #: _____

   Name and address of employer:

   _____

   _____

PART II:

1. Was the illness / injury due to a non-work related accident?
   [ ] NO - Go to Part III
   [ ] YES – Date of accident: _____/_____/_____
2. Was type of accident caused the illness / injury?
   [ ] Automobile [ ] Other
   [ ] Non-Automobile
   No-fault insurer is primary on those claims related to the accident.

   Name and address of no-fault or liability insurer:

   _____

   _____

   _____

   Insurance Claim #: _____
3. Was another party responsible for this accident?
   [ ] NO - Go to Part III
   [ ] YES – Liability insurer is primary only for those claims related to the accident.

   Name and address of no-fault or liability insurer:

   _____

   _____

   _____

   Insurance claim #: _____

PART III:

1. Are you entitled to Medicare based on:
   [ ] Age – go to Part IV
   [ ] Disability – go to Part V
   [ ] End stage renal disease – go to Part VI

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PART IV: AGE

1. Are you currently employed?
   [ ] NO – date of retirement _____/_____/_____
   [ ] YES – Name and address of employer:
   _____
   _____
   _____

2. Is your spouse currently employed?
   [ ] NO – date of retirement _____/_____/_____
   [ ] YES – Name and address of spouse's employer:
   _____
   _____
   _____

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment:
   [ ] NO – STOP!
   Medicare primary unless the patient answered yes to questions in Part I or II.
   [ ] YES – go to #4

4. Does the employer that sponsors your GHP employ 20 or more employees?
   [ ] NO – STOP! Medicare primary unless the patient answered yes to questions in Part I or II.
   [ ] YES – STOP! Group Health Plan is primary.
   Name and address of GHP: Name of policyholder:
   _____
   _____ _____
   _____ Relationship:
   Policy # and Group #:
   _____ _____

Signature: Date:	Witness: Date:

PART V: DISABILITY

1. Are you currently employed?
   [ ] NO – date of retirement: ____/_____/_____
   [ ] YES – name and address of employer:
   _____
   _____
   _____

2. Is a family member currently employed?
   [ ] NO
   [ ] YES – name and address of employer:
   _____
   _____
   _____

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER (Unless the patient answered yes to questions in Part 1 or Part II)

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment:
   spouse's current employment:
   [ ] NO – STOP!
   Medicare primary unless the patient answered Yes to questions in Part I or II
   [ ] YES – go to #4

4. Does the employer that sponsors your GHP employ 20 or more employees?
   [ ] NO – STOP! Medicare primary unless the patient answered Yes to questions in Part I or II.
   [ ] YES – STOP! Group Health Plan is primary.
   Name and address of GHP: Name of policyholder:
   _____
   _____ _____
   _____
   Policy # and Group #: Relationship:
   _____ _____

PART VI: END STAGE RENAL DISEASE (ESRD)

1. Do you have group health plan (GHP) coverage?
   [ ] NO – STOP! Medicare is primary
   [ ] YES – name and address of GHP:
   _____
   _____
   _____
   Policy # and group #:

2. Have you received a kidney transplant
   [ ] NO
   [ ] YES – date of transplant:
   _____/_____/_____

3. Have you received maintenance dialysis treatments?
   [ ] NO
   [ ] YES – date dialysis began:
   _____/_____/_____
   If participated in self-dialysis

BROOKS Rehabilitation

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Patient Name:_____

Account: _____

_____
Name of policyholder / relationship:

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

_____

_____

_____

4. Are you within the 30-month coordination period?
   [ ] NO – STOP! Medicare is primary
   [ ] YES

6. Was your initial entitlement to Medicare based on ESRD?
   [ ] NO – Initial entitlement based on age or disability

   [ ] YES – STOP! GHP continues to pay primary during the 30-month coordination period

program, provide date training started: ____/____/____

5. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
   [ ] NO – STOP! GHP is primary during the 30-month coordination period
   [ ] YES

7. Is the GHP primarily based on age or disability entitlement?
   [ ] NO –Medicare continues to pay primary
   [ ] YES – GHP continues to pay primary during 30-month coordination period

Signature:	Date:	Witness:	Date: