MEDICARE SECONDARY PAYOR SCREENING FORM

PATIENT NAME ____

HIC # (Medicare #) (________--______--__________

1. ARE YOU CURRENTLY WORKING FULL OR PART-TIME? __YES ___NO

2. IF YOU ARE MARRIED, IS YOUR SPOUSE CURRENTLY WORKING FULL OR PART-TIME? ____YES ___NO

   IF YES, HOW MANY EMPLOYEES DOES YOUR EMPLOYER OR YOUR SPOUSE'S EMPLOYER HAVE? _____
   IF NO, PLEASE INDICATE RETIREMENT DATE: YOU____SPOUSE

3. ARE YOU COVERED UNDER AN EMPLOYER GROUP HEALTH PLAN BASED ON YOUR CURRENT EMPLOYMENT, OR THE CURRENT EMPLOYMENT OF YOUR SPOUSE? _____YES _____NO IF YES, PLEASE PROVIDE:

   NAME OF INSURED____
   RELATIONSHIP TO PATIENT (SELF, SPOUSE) ____________________
   NAME OF EMPLOYER ______________________________________
   ADDRESS____
   CITY ____________________STATE _________________ ZIP ______
   GROUP IDENTIFICATION #_____POLICY # _____________________

4. ARE YOU ENTITLED TO BLACK LUNG MEDICAL BENEFITS?____ YES)___NO
   WAS THIS SERVICE FOR TREATMENT OF A WORK RELATED INJURY OR ILLNESS? __YES __NO IF YES, PLEASE PROVIDE:

   NAME OF WORKER'S COMPENSATION AGENCY: ________________________
   ADDRESS_________________________
   CITY ________STATE _____ZIP _____

   EMPLOYER NAME____
   ADDRESS _______________________
   CITY ________STATE _____ZIP ____

5. WAS THIS SERVICE FOR THE TREATMENT OF AN ILLNESS OR INJURY WHICH RESULTED FROM AN AUTOMOBILE OR OTHER ACCIDENT? ____YES ____NO IF YES, PROVIDE:

   NAME OF INSURER (AUTOMOBILE OR NON-AUTOMOBILE LIABILITY OR NO-FAULT)_________________________
   ADDRESS____________________________
   CITY ________STATE _____ZIP _______

6. ARE THE SERVICES TO BE PAID BY A GOVERNMENT PROGRAM SUCH AS A RESEARCH GRANT: ____YES ____NO