CHESAPEAKE REGIONAL
MEDICAL CENTER

MEDICARE SECONDARY PAYER QUESTIONAIRE

		D	A	*E
1.	**Are you entitled to Medicare coverage solely on the basis of** **D**isability, **A**ge or **E**nd Stage Renal Disease (ESRD)? ***If "E", questions 13-16 are required*** ***If "D", question 11 is required***			
2.	**Is this illness/injury covered by Worker's Compensation?** *If YES, Workers Compensation is primary payer.*	Y		N
3.	**Is this illness/injury covered by the Black Lung Program?** *If YES, Black Lung is primary payer*	Y		N
4.	**Do you have a Medicare Replacement plan (ex-Secure Horizons)?** *If "YES" do not bill Medicare-claims should be sent to replacement plan address*	Y		N
5.	**Is this illness/injury due to an automobile accident?** *If "YES" do not bill Medicare-claims should be sent to liability insurance*	Y		N
6.	**Do you feel that another party is responsible for this illness/injury?** *If "YES" do not bill Medicare-claims should be sent to the third party*	Y		N
7.	**Are these services to be paid by a government agency such as a research grant?** *If YES, government research program will pay primary benefits for these services*	Y		N
8.	**Are you or your spouse actively employed and covered by a Group Health Plan (GHP) with that company?** *If YES, _____ 20+ employees GHP is primary.* *If No, Retirement Date: _____ If Unknown, use Medicare eligibility date.* *If No, spouse retirement date: _____ If Unknown, use Medicare eligbility date.*	Y		N
9.	**Have you been confined as an inpatient to a hospital within the last 60 days?**	Y		N
10.	**Has the Department of Veterans Affairs (DVA) authorized and agree to pay for your care at this facility?** *If "YES" do not bill Medicare - claims should be sent to the VA*	Y		N
11.	**Is the patient and/or spouse or any other family member actively employed that covers you with a Group Health Plan (GHP) with that company and has > than100 employees?** ***If YES, GHP is primary (under 65 on Disability)*** ***If < than 100, Medicare is primary***	Y		N
12.	**Is today's visit directly related to a diagnosis that is being covered by hospice?** *If "YES" do not bill Medicare - claims should be sent to the hospice organization*	Y		N
13.	**Have you completed the 30-month ESRD Coordination Period?** *If YES, Medicare is primary. If no, GHP is primary*	Y		N
14.	**Have you completed the 30-month COB period for kidney transplant?** *If YES, Medicare is primary. If no, GHP is primary.*	Y		N
15.	**Have you completed the 30-month COB period for self-dialysis training?** *If YES, Medicare is primary. If no, GHP is primary.*	Y		N
16.	**Do you (patient) and /or spouse or another family member have a Group Health Plan (GHP)?**	Y		N

CRMC is required by Federal regulations to obtain this information for all services rendered to Medicare beneficiaries and will not assume responsibility for fraudulent responses provided. If you need further clarification or information about the questions being asked, you can access information at the CMS website www.cms.gov or call 1-800-MEDICARE. You may also ask a Patient Access Associate for further guidance. Thank you for allowing Chesapeake Regional Medical Center to be your choice for life.

Completed by: _____

Patient Label