# MEDICARE SECONDARY PAYER QUESTIONNAIRE
# (TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

**NAME:**_____

**DATE OF SERVICE:**_____

(If any answer to Questions 1a through 4 is yes, the corresponding section of the (Other Insurance" form must be filled out completely.)

1. Is the patient a veteran? ☐ YES ☐ NO

   a. Did the VA refer you here for treatment? ☐ YES ☐ NO

   b. Does the patient have a VA "fee basis ID card"? ☐ YES ☐ NO

2. Do you have a Federal Black Lung Card? ☐ YES ☐ NO

3. Is this medical condition due to an accident of any kind? ☐ YES ☐ NO

   If yes, was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐

4. Is the patient covered by an employer's health insurance plan through their own employment or that a of a family member? (Not retiree coverage) ☐ YES ☐ NO

**PATIENT SIGNATURE** **DATE**