June E. Nyden CANCER CENTER

Medicare Secondary Payer Questionnaire

(To be completed by all Medicare Patients)

Name: _____ DOB: _____ MRN: _____

Today's Date: _____

<u>If any answer to questions 1a through 4 is YES</u>, the corresponding section of the PATIENT REGISTRATION FORM (Section: Financial Information) 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 ___
   c. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility? YES ___ NO ___
2. Are you currently receiving Black Lung (BL) Benefits? YES ___ NO ___
   a. Are the services to be paid by a government research program? YES ___ NO ___
3. Is the medical condition due to an accident of any kind? YES ___ NO ___
   a. 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 of a family member (not retiree coverage)? YES ____ NO ____
5. Is the patient entitled to Medicare based on: Age, Disability, or End-Stage Renal Disease (ESRD) YES ___ NO ____