HC A Physician Services

Medicare Primary/Secondary Determination Form

Please select one statement that applies to you to determine if Medicare insurance is primary or secondary.

❑ I am **Over 65**, **married**, and:

- ❑ My spouse and I are both fully retired — *Medicare is **primary** for me*
- ❑ I work full or part-time (my spouse is retired) for a company with:
  - ❑ Less than 20 employees — *Medicare is **primary** for me*
  - ❑ More than 20 employees — *Medicare is **secondary** for me*
- ❑ I work full or part-time; however I have opted not to participate in my employer's health care plan — *Medicare is **primary** for me*
- ❑ My spouse works full or part-time (I am retired) for a company with:
  - ❑ Less than 20 employees — *Medicare is **primary** for me*
  - ❑ More than 20 employees — *Medicare is **secondary** for me*
- ❑ My spouse works full or part-time (I am retired); however I have opted not to participate in my spouse's employer's healthcare plan — *Medicare is **primary** for me*

❑ I am **Over 65**, **not married** (includes widowed) and:

- ❑ I am fully retired — *Medicare is **primary** for me*
- ❑ I work full or part-time (my spouse is retired) for a company with:
  - ❑ Less than 20 employees — *Medicare is **primary** for me*
  - ❑ More than 20 employees — *Medicare is **secondary** for me*
- ❑ I work full or part-time; however I have opted not to participate in my employer's health care plan — *Medicare is **primary** for me*

❑ I am **Under 65**, **disabled** and:

- ❑ I ❑ do not have ❑ have health coverage through LGHP with an employer who has 100 or more employees.
- ❑ I ❑ do not have ❑ have health coverage through anyone else.

❑ Other Conditions

- ❑ I have end-stage renal disease — *Medicare is **secondary** for me*
- ❑ I am entitled to Black Lung Benefits — *Medicare is **secondary** for me*
- ❑ I am entitled to Veteran's Benefits — *Medicare is **secondary** for me*
- ❑ COBRA benefits apply — *Medicare is **secondary** for me*
- ❑ I was injured in an accident — *Medicare is **secondary** for me*

X ______________________ ______________________ __________

Signature of Beneficiary/Patient | Print Name of Beneficiary/Patient | Date

Reviewed: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date

Patient's Name	Account No.	Medicare No.

You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

Does the patient have an HMO policy? ☐ No ☐ Yes

If Yes, name, address and phone of HMO:

Does the HMO replace Medicare? ☐ No ☐ Yes

If Yes, the HMO will be primary. If No, it will be secondary.

Is this patient an inpatient? ☐ No ☐ Yes

Was the patient given Important Message? ☐ No ☐ Yes

If No, why not?

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ No
   - ☐ Yes; Date benefits began:

   If Yes, 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 program 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 work related accident or condition?
   - ☐ No; **Go to Question 5.**
   - ☐ Yes; Date of injury/illness:

   Name, address and phone of Workers Compensation Plan:

   Policy or ID Number:

   Name, address and phone number of your employer:

   If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Date of accident:

6. What type of accident caused the illness/injury?
   - ☐ Automobile ☐ Non-Automobile

   Name, address and phone of no-fault or liability insurer:

   Insurance Claim Number:

   No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**

   - ☐ Other (explain)

7. Was another party responsible for this accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Provide name, address and phone of any liability insurer:

   Insurance claim number:

   If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:
   - ☐ Age; **Go to Questions 9 – 12.**
   - ☐ Disability; **Go to Questions 13 – 16.**
   - ☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?
   - ☐ No; Date of retirement:
   - ☐ Yes; Provide name, address and phone of your employer:

10. Is your spouse currently employed?
    - ☐ No; Date of retirement:
    - ☐ Yes; Provide name, address and phone of spouse's employer:

    If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer.

    Do not proceed any further.

    If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
    - ☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*
    - ☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
   - ☐ No; **Stop.** *Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
   - ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information.*

   Name, address and phone of GHP:

   Policy ID Number:

   Group ID Number:

   Name of Policy Holder — Relationship to Patient

13. Are you currently employed?
   - ☐ No; Date of Retirement
   - ☐ Yes; Provide name, address and phone of your employer:

14. Is a family member currently employed?
   - ☐ No
   - ☐ Yes; Provide name, address and phone of employer:

   If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
   If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
   - ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
   - ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
   - ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
   - ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

   Name, address and phone of GHP:

   Policy ID Number:

   Group ID Number:

   Name of Policy Holder — Relationship to Patient

17. Do you have group health plan (GHP) coverage?
   - ☐ No: Stop. *Medicare is Primary.*
   - ☐ Yes; Provide name, address and phone of GHP:

   Policy ID Number

   Group ID Number:

   Name of Policy Holder — Relationship to Patient

   Name, address and phone of employer, if any from which you received GHP coverage:

18. Have you received a kidney transplant?
   - ☐ No
   - ☐ Yes; Date of Transplant:

19. Have you received maintenance dialysis treatments?
   - ☐ No
   - ☐ Yes; Date dialysis began:

   If you participated in self dialysis training program, provide date training started:

20. Are you within the 30 month coordination period?
   - ☐ No; **Stop.** *Medicare is Primary.*
   - ☐ Yes

21. 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

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
   - ☐ No; *Initial entitlement based on age or disability.*
   - ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
   - ☐ No; *Medicare continues to pay Primary.*
   - ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X ______________________________ Patient or Representative / Relationship

X ______________________________ Witness — Date