CancerCare
NORTHWEST

Medicare Secondary Payor Screening Form

Patient Name: _____ Date: _____

Medicare Number:_____ Acct #:_____

(Medicare patients – please answer the following questions. If your response is "Yes" to any question, answer the other questions in that section.)

Illness/Injury Caused by Accident

1. Is the illness or injury due to <u>any</u> <u>kind</u> of accident?

☐ No – Proceed to question #2.

☐ Yes – Medicare may be secondary. Check the appropriate box (A-E) and answer the questions.

☐ A. Motor vehicle: name of patient's automobile insurer _____

☐ No fault insurance (auto insurance primary)

☐ Liability insurance (bill Medicare primary for conditional payment with insurance information)

☐ B. Motor vehicle: name of <u>third</u> <u>party's</u> liability insurer _____

(Bill Medicare primary for conditional payment. Send name, address and numbers of insurance, attorney name, etc.)

☐ C. Work Related: name of Workman's Comp insurer _____

(Workman's Compensation primary)

☐ D. Slip and fall: explain where fall occurred _____

If fall occurred at place other than patient's home, determine if liability claim or suit will be filed or if any kind of compensation can be made.

☐ No ☐ Yes – explain, giving information on third party

_____

(Bill Medicare primary with liability information)

☐ E. Other accident, no third party can pay. Give description of accident/location

_____

(Bill Medicare primary with pertinent documentation)

Coverage through other Governmental Entity

2. Does the patient have coverage through the VA, Dept. of Labor Black Lung Program?

☐ No – Proceed to question #3.

☐ Yes – The entity the patient has coverage with must be billed primary to Medicare. Medicare may reject the claim unless the entity pays as primary or submits a denial of service.

Employer Group Coverage for those 65 and Over

3. Is the patient 65 or older and employed at the time of this service?

☐ No – Proceed to question #4.

☐ Yes – Give the patient's date of birth_____

(over)

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Give the name of the patient's company/employer _____

A. Does the employer employ 20 or more employees? ☐ No ☐ Yes

B. Does the patient have an Employer Group Health Plan (EGHP) by reason of his/her current employment?

☐ No ☐ Yes – give name of EGHP _____

4. Does the patient have a spouse who is employed at the time of this service?

☐ No – Proceed to question #5.

☐ Yes – give the patient's date of birth _____

Give the name of spouse's company/employer _____

A. Does the employer employ 20 or more employees? ☐ No ☐ Yes

B. Does the spouse have an Employer Group Health Plan (EGHP) by reason of his/her current employment that covers the patient? ☐ No ☐ Yes – give name of EGHP _____

(If the patient is 65 or over and has answered "yes" to A and B, the EGHP shown is to be billed before Medicare. If the patient also has an EGHP (see #3), then bill Medicare third.)

Employer Group Coverage for those entitled to Medicare solely due to End Stage Renal Disease

5. Is the patient under the age of 65, entitled to Medicare <u>solely</u> because of End Stage Renal Disease (ESRD) and in the first 12 months of Medicare entitlement?

☐ No – Proceed to question #6.

☐ Yes – Patient's date of entitlement shown on the Medicare card _____

Does the patient have coverage through his/her or his/her spouse's, parent's, or a guardian's EGHP?

☐ No ☐ Yes – give the name of the employer _____

Give the name of the EGHP _____

(If the patient answered "yes" to both questions, the EGHP is primary to Medicare.)

Employer Group Coverage for those entitled to Medicare solely because of Disability

6. Is the patient under the age of 65, entitled to Medicare <u>solely</u> (does not have/has not had ESRD) because of disability?

☐ No

☐ Yes – Give the patient's date of birth _____

Does the patient have coverage through his/her or his/her spouse's, parent's, or a guardian's EGHP?

☐ No ☐ Yes – give the name of each insured whose policy covers the patient:

a. _____ b. _____

Give name of corresponding employer

a. _____ b. _____

Give name of corresponding EGHP

a. _____ b. _____

(If patient answered "yes" to both questions, the EGHP(s) is/are primary to Medicare.)

NOTE: It is important to ask all questions and document all answers regarding MSP. A provider may be held liable if an overpayment occurs and Medicare finds the provider furnished erroneous information or failed to disclose facts it knew were relevant to payment.

Patient/Representative Signature: _____ **Date:** _____