Medicare Secondary Payor
(MSP) Questionnaire – Page 1

PSS Name: ______________________
Facility Phone: ______________________
Person Contacted @ HHA:
Name:

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Patient Name: ______________________
Medicare Number: ______________________
(exactly as appears- Red-White-Blue Government Medicare Card)

Office use only
Clinic Name: ________
Patient Acct#: ________
Database: ________

1. **Have you received Home Health Care of any kind in the past 60 days or currently are residing in a Skilled Nursing Facility? ....** **Yes No**
   Agency Name/Facility Name: ______________________
   Phone: ______________________
   If in a Skilled Nursing Facility: **Are you on/in the "Medicare Unit"?** Yes No

2. **Are you entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program?..** **Yes No**
   If yes, Program Name: ______________________ Phone: ______________________
   Address, City, State, ZIP:
   ____
   NOTE: *The government program listed in question #2 will be primary to Medicare.*

3. **Was this injury/illness due to any of the following?**
   Work-related? **If yes**, date of accident/injury: ________ /________ /__________...... **Yes No**
   Auto accident? **If yes**, date of accident: ________ /________ /__________............. **Yes No**
   Accident on Property? (other than your own)(Example: store, restaurant, etc.) ….. **Yes No**
   If yes, date of accident: ________ /________ /________
   If yes, please give details of the accident:

   If yes, please provide the following information about the **liability insurance**:
   Insurance Name: ______________________ Phone: ______________________
   Address, City, State, ZIP:
   ____
   Contact Person/Adjustor's Name: ______________________
   Claim Number: ______________________ (**required**)
   NOTE: *Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare. Your understanding and cooperation is appreciated.*

4. **Do you feel you have a right to be compensated by a party who may have caused the injury or illness?..** **Yes No**
   If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness?.. Yes No
   If yes, Attorney's Name: ______________________
   Law Firm Name: ______________________
   Address: ______________________
   Phone number: ______________________

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Brielle Orthopedics, P.A.

Medicare Secondary Payor (MSP) Questionnaire – Page 2

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office use only

Patient Name: ____________________ **Clinic Name:** ____________________

Medicare Number: ____________________ **Patient Acct#:** ____________________

(exactly as displayed on Red-White-Blue Government Medicare Card) **Database:** ____________________

5. **Have you received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD)? ....** **Yes** **No**

   If yes, please provide the date of the transplant or start of dialysis: ____/____/____

   If the date is less than 30 months ago: **Are you currently covered under group insurance provided by your or a family member's employer?** Yes No

   If yes – the group insurance will be primary **If no** – Medicare will be primary

6. **Are you currently employed?..........** **Yes** **No**

   If yes, Does your employer employ more than 20 employees?.......... Yes No

   If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

   Is your spouse currently employed?.......... **Yes** **No**

   If yes, Does his/her employer employ more than 20 employees?.......... Yes No

   If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

   (**NOTE:** If both are not currently employed, then Medicare is primary.)

7. **If you've answered No to questions 1 – 6 AND your Medicare coverage is due to age or disability:**

   Do you have a group insurance plan through another family member's current employer?.......... **Yes** **No**

   If yes – the group insurance will be primary **If no** – Medicare will be primary

   Do you have any benefits through TriCare (formerly Champus)?.......... **Yes** **No**

8. **If you answered YES to questions 6 or 7, please complete the following group insurance information for the proper billing of your account:**

Insurance Co. Name: ____________________

Address: ____________________

City, State, ZIP: ____________________

Phone: ____________________

Employer Name: ____________________

Insured's Name: ____________________

Policy Identification Number: ____________________ *(Sometimes referred to as the health insurance benefit package number.)*

Group Identification Number: ____________________

____

Patient signature Date

____

Appointed Representative signature Relationship

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