CACC PHYSICAL THERAPY

Patient Name _____ Medicare ID # _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

YES	NO	QUESTION?
○	○	**1. Are you receiving Black Lung Benefits?** If NO, proceed to Question #2. If YES, BL is primary only for claims related to BL.
○	○	**2. Are the services to be paid by a government program such as research grant?** If NO, proceed to Question #3. If 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?** If NO, proceed to Question #4. If YES, DVA is primary for these services.
○	○	**4. Was the illness /injury due to a work related accident/condition?** If NO, proceed to Question #5. If YES, complete blanks below: Date of injury/accident _____ Name/Address of WC plan _____ _____ _____ Policy Number _____ Name/Address of Employer _____ _____ _____ (WC is primary for claims related to work related injuries or illness)
○	○	**5. Was the illness/injury due to a non-work related accident?** If NO, proceed to Question #6. If YES, complete blanks below: Date of accident _____ Cause: Auto _____ Non-auto _____ Other Party Responsible_____ Name/Address of Auto or Liability Insurer _____ _____ _____ Insurance claim # _____ (Auto/Liability Insurer is primary payer for claims related to the accident)
○	○	**6. Are you entitled to Medicare based on Age? (Age 65 or over)** If NO, proceed to Question #7. If YES, go to AGE QUESTIONS (On Page 2).
○	○	**7. Are you entitled to Medicare based on Disability?** If NO, proceed to Question #8. If YES, go to DISABILITY QUESTIONS (On Page 2).
○	○	**8. Are you entitled to Medicare based on ESRD (End Stage Renal Disease)?** If YES, go to ESRD QUESTION #3 (On Page 2).

CACC PHYSICAL THERAPY

Patient Name _____ Medicare ID # _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE…Age, Disability, & ESRD Questions (Page 2)

YES	NO	QUESTION?
◯	◯	**1. Are you currently employed?** If NO, Retirement Date _____ If YES, Name/Address of Employer _____
◯	◯	**2. Is your spouse or family member currently employed?** If NO, Retirement Date _____ If YES, Name/Address of Employer _____
◯	◯	**3. Do you have Group Health Plan (GHP) coverage based on your own or your family member's current employment?** If NO, Medicare is primary. (STOP QUESTIONNAIRE HERE!) If YES, For AGE …GO TO 4a. For DISABILITY…GO TO 4b. For ESRD…GO TO 4c.
◯ ◯ ◯	◯ ◯ ◯	**4a. AGE: Does the employer that sponsors your GHP employ 20 or more employees?** **4b. DISABILITY: Does the employer that sponsors your GHP employ 100 or more employees?** **4c. ESRD: Date of kidney transplant? _____** **Date dialysis began? _____** **(GHP is primary for 30 month coordination period…complete info below)** If NO, Medicare is primary. If YES, GHP is primary. Complete the information below: Name/Address of GHP _____ ID # _____ Group # _____ Policy Holder _____ Relation to patient _____

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (Check Yes or No)
Have you received any medical care (Ex. PT, ST, OT, Nursing, Aide) from a Home Health Agency in the past 60 days? **YES** ◯ **NO** ◯

MEDICARE PAYMENT AUTHORIZATION
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request that payment of authorized benefits be made on my behalf to Phoenix Physical Therapy. This authorization is valid for a period of 2 years from the date which I have signed.

Patient or Authorized Signature _____ Date _____