CROCKETT MEDICAL CLINIC, INC

Medicare Secondary Payer (MSP) Questionnaire

If you have Medicare Coverage, please complete the following

Name _____ **DOB:** _____ **SS#** _____

1. Are you receiving Black Lung Benefits? **YES** No
2. Are the services today covered by government research benefits? **YES** No
3. Has Department of Veterans Affairs authorized to pay for your care at this facility? **YES** No
4. Are you a Medicare Beneficiary due to End Stage Renal Disease? **YES** No
5. Is your illness/injury due to a **work related or auto accident**? **YES** No

WORK: Claim must be filed with Workers Comp

AUTO: Receipt will be given for paid services for patient to file with Automobile liability insurance

6. Do you have Medicare because of your age? Yes No
7. Do you have Medicare because of Disability? Yes No
8. Are you currently employed? **YES** No

   IF YES, do you have insurance through your employer? **YES** No
9. Do you have a spouse currently employed? **YES** No

   IF YES, do you have insurance through your spouse's employer? **YES** No

Guidelines:

Medicare due to AGE with insurance through self or spouse employment:

Employer with 20 or more employees: Commercial is Primary / Medicare is Secondary

Medicare due to Disability with insurance through self or spouse employment:

Employer with 100 or more employees: Commercial is Primary / Medicare is Secondary

Signature _____ Date: _____