



Medicare

MEDICARE PART A INTERMEDIARY

To all Medicare Providers:

Federal Law (42 USC 489.20 (f)) requires that providers of medical services to Medicare beneficiaries determine whether or not there is other insurance coverage for the beneficiary that should be billed before a bill is submitted to Medicare. Providers must be able to document that they have screened for other insurance coverage by asking the beneficiary questions which will identify if other insurance is available. The Medicare Questionnaire contains all of the necessary questions that need to be asked of the beneficiary to determine if there is other insurance that is primary to Medicare.

Attached is a Medicare Secondary Payor (MSP) Questionnaire developed by AdminaStar Federal, Inc. It is designed to screen for MSP programs in the registration or the billing department. Accurately completing the Questionnaire ensures expedient payments to the providers, as well as, compliance with Medicare rules and regulations. It also helps prevent future recovery action for incorrect billings.

Thank You

AdminaStar Federal, Inc.
Medicare Secondary Payor Department

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

(9/99)

BENEFICIARY INFORMATION:

MEDICARE BENEFICIARY: _____ PATIENT ACCOUNT #: _____
HIC # _____ DCN: _____ PROVIDER # _____
DATES OF SERVICE FROM: _____ THROUGH: _____ PERSON WHO SUPPLIED INFORMATION: _____
RELATIONSHIP TO PATIENT: _____ PROVIDER REP NAME: _____ DATE: _____

1. WORKERS' COMPENSATION (WC):

PER THE PATIENT, SHOULD THE ILLNESS/INJURY BE COVERED BY A WC CLAIM? _____ YES _____ NO
IF YES, THIS SHOULD BE AN MSP OR CONDITIONAL CLAIM, NOT MEDICARE PRIMARY. PLEASE NOTE, WC IS PRIMARY ONLY FOR CLAIMS
RELATED TO A WC INJURY.

ORIGINAL DATE OF ILLNESS/INJURY: _____ CLAIM NUMBER: _____
NAME OF WC PLAN: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
NAME OF EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

2. FEDERAL BLACK LUNG (BL):

IS THE PATIENT COVERED BY THE BL PROGRAM? _____ YES _____ NO
DATE BENEFITS BEGAN: _____ (BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL)
IF YES, ARE YOU ABLE TO DETERMINE AT THIS TIME IF THE CLAIM WILL BE COVERED BY THE DEPT. OF LABOR, PER THE ACCEPT-
ABLE DIAGNOSIS LIST? _____ YES _____ NO
IF YES, THIS SHOULD BE AN MSP OR CONDITIONAL CLAIM, NOT MEDICARE PRIMARY.

3. DEPARTMENT OF VETERANS AFFAIRS (DVA):

IS THE PATIENT ENTITLED TO BENEFITS THROUGH THE DVA? _____ YES _____ NO
IF YES, DOES THE PATIENT WANT THE DVA TO BE CONTACTED FOR AUTHORIZATION OF THESE SERVICES? _____ YES _____ NO

4. PUBLIC HEALTH SERVICES (PHS):

ARE THE SERVICES TO BE PAID BY A GOVERNMENT PROGRAM SUCH AS A RESEARCH GRANT? _____ YES _____ NO
IF YES, THE GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.
WHAT IS THE NAME OF THE PHS? _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

5. ACCIDENT:

ARE THESE SERVICES THE RESULT OF AN ACCIDENT? _____ YES _____ NO

A. NON-LIABILITY INSURANCE:

IF YES, WHAT TYPE OF ACCIDENT WAS THIS OR GIVE A DESCRIPTION OF THE ACCIDENT (FOR EXAMPLE: AUTO, SLIP AND FALL,
MALPRACTICE, PRODUCT LIABILITY, HOMEOWNERS)? _____
DATE OF ACCIDENT: _____ LOCATION OF ACCIDENT (HOME, RESTAURANT, ETC.): _____
IS NON-LIABILITY INSURANCE AVAILABLE (FOR EXAMPLE: PREMISES MEDICAL, AUTO MEDICAL COVERAGE, NO FAULT,
HOMEOWNERS PREMISES)? _____ YES _____ NO
IF YES, NAME OF THE INSURANCE COMPANY _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
WHO IS LISTED AS THE INSURED? _____

B. LIABILITY INSURANCE:

DOES THE PATIENT FEEL SOMEONE ELSE IS RESPONSIBLE FOR THE ACCIDENT/INJURY? _____ YES _____ NO
IF YES, NAME OF THE PATIENT'S ATTORNEY OR THE RESPONSIBLE PARTY'S INSURANCE COMPANY? _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
NAME OF RESPONSIBLE INSURED PARTY? _____

6. EMPLOYER GROUP HEALTH PLAN (EGHP):

IS THE PATIENT COVERED BY ANY EGHP, INCLUDING FEDERAL EMPLOYEE HEALTH BENEFITS OR ANY RETIREMENT POLICY? _____ YES _____ NO

IF NO, THIS QUESTIONNAIRE IS COMPLETE. IF YES, CONTINUE.

7. WORKING AGED

IS THE PATIENT 65 YEARS OR OLDER? YES NO
IS THE PATIENT CURRENTLY EMPLOYED BY AN EMPLOYER OF 20 OR MORE EMPLOYEES? YES NO
IF YES, NAME OF THE EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IS THE SPOUSE CURRENTLY EMPLOYED BY AN EMPLOYER OF 20 OR MORE EMPLOYEES? YES NO
IF YES, NAME OF THE EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IF THE PATIENT OR SPOUSE IS EMPLOYED BY AN EMPLOYER OF 20 OR MORE EMPLOYEES, IS THE PATIENT COVERED BY THE EGHP YES NO
IF YES, NAME OF THE EGHP: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
POLICY#: _____ GROUP IDENTIFICATION #: _____
IF THE BENEFICIARY IS NO LONGER EMPLOYED, PLEASE GIVE A RETIREMENT DATE IF POSSIBLE: _____(MM/DD/CCYY)
IF THE SPOUSE IS NO LONGER EMPLOYED, PLEASE GIVE A RETIREMENT DATE IF POSSIBLE: _____(MM/DD/CCYY)
NOTE: IF THE PATIENT IS COVERED THROUGH THEIR OWN OR A SPOUSE'S EGHP OF 20 OR MORE EMPLOYEES, THE EGHP SHOULD BE PRIMARY. PLEASE GO ON TO THE ESRD/DUAL ENTITLEMENT QUESTIONS.

8. DISABILITY

IS THE PATIENT UNDER THE AGE OF 65? YES NO
IF YES, IS THE PATIENT ENTITLED TO MEDICARE DUE TO A DISABILITY OTHER THAN THE END STAGE RENAL DISEASE? YES NO
IF YES, IS THE PATIENT CURRENTLY EMPLOYED BY AN EMPLOYER OF 100 OR MORE EMPLOYEES? YES NO
NAME OF THE EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IS A FAMILY MEMBER CURRENTLY EMPLOYED BY AN EMPLOYER OF 100 OR MORE EMPLOYEES? YES NO
NAME OF THE EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IS THE PATIENT COVERED BY THAT LARGE GROUP HEALTH PLAN? YES NO
NAME OF INSURANCE COMPANY: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
POLICY # _____ NAME OF POLICY HOLDER: _____
RELATIONSHIP TO THE PATIENT _____ GROUP IDENTIFICATION # _____
NOTE: IF THE PATIENT IS COVERED BY THEIR OWN OR A FAMILY MEMBER'S LGHP OF 100 OR MORE EMPLOYEES, THE LGHP SHOULD BE PRIMARY. PLEASE GO ON TO THE ESRD/DUAL ENTITLEMENT QUESTIONS.

9. END STAGE RENAL DISEASE (ESRD):

IS THE PATIENT COVERED BY AN EGHP THROUGH A CURRENT OR FORMER EMPLOYER OF ANY SIZE? YES NO
NAME OF GROUP HEALTH PLAN? _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
POLICY # _____ NAME OF POLICY HOLDER: _____
RELATIONSHIP TO THE PATIENT _____ GROUP IDENTIFICATION # _____
NAME OF THE EMPLOYER: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IS THE PATIENT WITHIN THE 30 MONTH COORDINATION OF BENEFITS PERIOD? YES NO
WHAT IS THE MONTH/YEAR OF THE FIRST REGULAR DIALYSIS? _____(MM/CCYY)
HAS THE PATIENT HAD A KIDNEY TRANSPLANT? YES NO
IF YES, DATE OF TRANSPLANT _____(MM/CCYY)
NOTE: IF THE PATIENT IS WITHIN THE 30 MONTH COORDINATION OF BENEFITS PERIOD, THE GHP SHOULD BE PRIMARY.

10. DUAL ENTITLEMENT

IS THE PATIENT ENTITLED TO MEDICARE ON THE BASIS OF EITHER ESRD AND AGE OR ESRD AND DISABILITY? YES NO
WAS THE PATIENT'S INITIAL ENTITLEMENT TO MEDICARE (INCLUDING SIMULTANEOUS ENTITLEMENT) BASED ON ESRD? YES NO
DOES THE WORKING AGED OR MSP DISABILITY PROVISION APPLY (I.E., IS THE GHP PRIMARY BASED ON THE AGE OR DISABILITY ENTITLEMENT)? YES NO
NOTE: IF YES TO THE LAST QUESTION, THE GHP REMAINS PRIMARY FOR THE 30 MONTH COB PERIOD.