SOUTHEAST REGIONAL PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

Medicare Secondary Payer Questionnaire

Patient Name:_____ Date of Birth:_____Date:_____

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung YES ☐NO ☐
Research Grant YES ☐NO ☐
Veteran Affairs YES ☐ NO ☐

2. Was illness/injury due to a work-related accident/condition?

☐YES ☐NO

If **YES**, answer the following:

☐Work- related accident.
☐Non-work-related accident, please describe:_____

3. Is the patient currently employed?

☐YES, full time ☐YES, Part Time ☐NO, Not employed ☐Retired, please provide date: _____

If **YES**, answer the following:

Do you have group health plan (GHP) coverage? ☐YES ☐NO
If **YES**, are there under or over 20 employees? ☐Under 20 ☐Over 20

4. Is the patient's spouse currently employed?

☐YES ☐NO

If **YES**, answer the following:

Does your spouse have group health plan (GHP) coverage? ☐YES ☐NO
If **YES**, are there under or over 20 employees? ☐Under 20 ☐Over 20

5. Is the patient entitled to Medicare benefits as a result of:

☐Age, provide age: _____
☐Disability? ☐YES ☐NO
☐End Stage Renal (Kidney) Disease? ☐YES ☐NO

If **YES**, answer the following:

Have you received a kidney transplant? ☐YES ☐NO
If **YES,** provide transplant date: _____
Have you received dialysis maintenance treatments? ☐YES ☐NO
If **YES,** provide dialysis start date:_____

6. Are you currently a patient in a skilled nursing facility such as a nursing home? ☐YES ☐NO

7. Are you covered by Medicaid? ☐YES ☐NO

I confirm that the above information is correct.

Patient Printed Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____