Penn Medicine
Princeton Medicine Physicians

Medicare Secondary Payer Questionnaire

Patient Name_____

Date_____

Medicare statute and regulations require that all entities that bill Medicare for items or services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services. Please complete the following:

Part I

Are you receiving Black Lung (BL) benefits?	☐Yes	☐No
If yes, date benefits began:		
Are the services today to be paid for by a government research program?	☐Yes	☐No
Are you entitled to benefits through the Department of Veterans Affairs (DVA?)	☐Yes	☐No
If yes, has the DVA authorized and agreed to pay for your care at this facility?	☐Yes	☐No
Is your illness/injury due to a work-related accident?	☐Yes	☐No
If yes, please provide accident information to the registration staff.		

Part II

Is your illness/injury due to a non-work-related accident?	☐Yes	☐No
If yes, please provide accident information to the registration staff.		

Part III

Are you entitled to Medicare based on age?	☐Yes	☐No
Are you entitled to Medicare based on Disability?	☐Yes	☐No
Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)?	☐Yes	☐No

PLEASE COMPLETE BACK SIDE OF FORM

Part IV

Are you currently employed?				
☐Yes	☐Yes, but retired from previous employment	☐No, Retired	☐No, but not retired	☐No, Never employed
If yes, Employer name:				
Do you have group health coverage through your current employer?			☐Yes	☐No
If yes, does your employer employ more than 20 people?			☐Yes	☐No
Do you have a spouse that is currently employed?				
☐Yes	☐Yes, but retired from previous employment	☐No, Retired	☐No, but not retired	☐No, Never employed	☐No, Not Married
If yes, Employer name:					
Do you have group health coverage through your spouse's current employer?			☐Yes	☐No
If yes, does your spouse's employer employ more than 20 people?			☐Yes	☐No