Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

Place Patient Label Here

Medicare Secondary Payor Questionaire

Account #: _____ **Patient:** _____ **Date:** _____

Employee: _____ **Completed by:** _____ **Relation:** _____

Is the Patient receiving Black Lung Benefits? NO / YES, date began: ____/____/____

Are the services to be paid by a government research program? NO / YES

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES

Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? NO / YES

Was the illness/injury due to work-related accident/condition? NO / YES

Was illness/injury due to a non-work-related accident? NO / YES

If yes, complete:

Date of injury/illness: ___/___/___

Workers' Comp Insurance? NO / YES

No-fault Insurance? NO / YES

Liability Insurance? NO / YES

ID /Claim Number: _____

Policyholder's Name: _____

Insurance Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS. NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD.

Is the Patient entitled to Medicare based on:

Age: NO / YES

Disability: NO / YES

End Stage Renal Disease (ESRD): NO / YES

If yes to ESRD, complete:

Has the patient received a kidney transplant? NO / YES: date: ____/____/____

Has the patient received maintenance dialysis treatments?

NO / YES: start date: ____/____/____

If patient participated in a self dialysis training program,
provide training start date: ____/____/____

Is patient within the 30-month Coordination of Benefits period?
NO / YES: start date: ____/____/____

Is the patient entitled to Medicare on the basis of either ESRD & age or
ESRD & disability NO / YES

Was initial entitlement to Medicare (simultaneous or dual entitlement) based on
ESRD? NO / YES

Does the working aged or disability MSP provision apply? NO / YES

PLEASE NOTE THAT BOTH "AGE" AND "ESRD" OR "DISABILITY" AND "ESRD" MAY BE SELECTED SIMULTANEOUSLY. AN INDIVIDUAL CAN NOT BE ENTITLED TO MEDICARE BASED ON "AGE" AND "DISABILITY" SIMULTANEOUSLY. PLEASE COMPLETE ALL PARTS ASSOCIATED WITH THE PATIENT'S SELECTIONS.

Is the Patient currently employed:

No: _____ Never employed.
No: _____ Retired from employment, retirement date: _____/_____/_____
Yes: _____ Carry Insurance at work? If yes, more than 20 employees?

Is the Patient's Spouse currently employed?

No: _____ Never employed.
No: _____ Retired from employment, retirement date: _____/_____/_____
Yes: _____ Carry Insurance at work? If yes, more than 20 employees?

Is the Patient's Family Member currently employed?

No: _____ Never employed.
No: _____ Retired from employment, retirement date: _____/_____/_____
Yes: _____ Carry Insurance at work? If yes, more than 20 employees?

If the Patient or Spouse is employed, complete:

Employer Name:_____

Employer Address: _____

City: _____State: _____ Zip: _____

Carry Insurance thru work? No: _____ Yes: _____

ID Number: _____Group Number:

Policyholder Name: _____

Name of Insurance: _____

City: _____ State: _____ Zip:

Are you a member of a Medicare Replacement Plan - MHMO or PFFS?
NO / YES

Policyholder Name: _____
ID / Policy #: _____
Insurance Name: _____
Insurance Address: _____
City: _____State: _____ Zip: _____