

Medicare Primary Payer Questionnaire

The questions listed below are for beneficiaries or older, and is used to comply with Medicare Regulation 42 CFR 489.20(F).

1. Are you currently working full or part time? Yes No
2. If married, is your spouse working full or part time? Yes No
3. Are you currently under any employer group health plan? Yes No
If Yes, please provide the following information:
Name of Insured: _____
Relationship to Patient: _____
Name of Employer: _____
Name of Insurance Carrier: _____
Group/Policy# _____
4. Are you entitled to Black Lung Benefits? Yes No
5. Is this service for treatment work related? Yes No
If Yes, please provide the following information:
Name of Insurer _____
Name of Employer _____
Date of Injury _____
Policy/Claim# _____
6. Is this service for treatment related to an auto injury? Yes No
Name of Insurer _____
Name of Policyholder _____
Date of Injury _____
Claim# _____
7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Patient Name _____ Date _____

Patient Signature _____