Marsh Family Medicine PLLC, Medicare Secondary Payer Form

DATE_____ PATIENT NAME_____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident, or Workman's Compensation? q Yes q No
2. Is illness covered by the Black Lung Program or Veteran's Administration program? q Yes q No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? q Yes q No

4a. If under age 65, is your Medicare coverage due to disability? q Yes q No

4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? q Yes q No

5. If 65 and over, is patient covered by Employer Group Health Plan through patients or spouses current employer? q Yes q No

Billing Notes:

A. If patient responds "No" to questions 1-5, Medicare is primary.

B. If patient responds "Yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company_____

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Name of Policy Holder_____

Policy Number_____

Policy Holder's Employer Name_____

Policy Holder's Employer Address_____

Date of Accident (if applicable)_____

Patient's Signature_____Date_____