New Braunfels Spine and Pain Surgery Center
Medicare Secondary Payer Screening Form

(1) Are you CURRENTLY a patient at a Skilled Nursing Facility? If YES please provide: Facility Name:_____ Address: _____ Phone Number:	YES	NO
(2) Are you CURRENTLY under the care of Hospice? If YES please provide: Facility Name:_____ Address: _____ Phone Number:	YES	NO
(3) Are you entitled to Medicare based on AGE?	YES	NO
(4) Are you entitled to Medicare based on DISABILTY?	YES	NO
(5) Are you entitled to Medicare based on ESRD (End Stage Renal Disease)?	YES	NO
(6) Do you have group health plan (GHP) coverage based on you own, or a spouse's, CURRENT employment?	YES	NO
(7) Do you have other Primary Insurance? If YES please provide: Insurance Name:_____ Address: _____ Phone Number:	YES	NO
(8) Are you receiving Black Lung (BL) Benefits?	YES	NO
(9) Are the services to be paid by a government program such as a research grant?	YES	NO
(10) Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?	YES	NO
(11) Was the injury due to a work related accident/condition?	YES	NO
(12) Was the injury due to a non-work related accident? (Such as auto accident)	YES	NO

_____ _____

Signature of patient/guardian Date Signature of patient/guardian Date

_____ _____

Signature of patient/guardian Date Signature of Anesthesia Provider Date

_____ _____

Signature of patient/guardian Date Signature of Anesthesia Provider Date

PATIENT LABEL