

**MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)**

Name: _____

Date of Service: _____

(If any answer to questions 1a. through 4 is yes the corresponding section of the
“Other Insurance” form must be filled out completely.)

- | | Yes | No |
|---|-------|-------|
| 1. Is the patient a Veteran? | _____ | _____ |
| a. Did the VA refer you here for treatment? | _____ | _____ |
| b. Does the patient have a VA “fee basis ID Card?” | _____ | _____ |
| 2. Do you have a Federal Black Lung card? | _____ | _____ |
| 3. Is this medical condition due to an accident of any kind? | _____ | _____ |
| If yes was it: Work Related? _____ Auto? _____ Injured in own home? _____ | | |
| 4. Is the patient covered by an employer’s health insurance plan through their own employment or that of a family member?
(Not retiree coverage) | _____ | _____ |

WAIVER OF LIABILITY STATEMENT

Provider notice:

Medicare will only pay for services that it determines to be “reasonable and necessary” under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for:

Beneficiary Agreement:

I have been notified by my provider that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed,

Beneficiary signature