If you are a Medicare beneficiary, please answer the following questions. This is a Medicare requirement.

Medicare Secondary Payor Questionnaire – MSPQ

Date Completed: _____ Completed By: _____

Is the Patient entitled to Medicare based on

☐ AGE (over 64) ☐ DISABILITY ☐ END STAGE RENAL DISEASE

If married, what is the name of your spouse? _____

Is the patient employed? ☐ YES ☐ NO **Is the patient's spouse employed?** ☐ YES ☐ NO

Is the patient covered by an Employer Group Health Plan (EGHP) ? ☐ YES ☐ NO

If YES, does the employer have ☐ 20 employees or fewer ☐ 21 employees or more

☐ 100 employees or fewer ☐ 101 employees or more

Is the Patient or their Spouse retired? ☐ YES ☐ NO

Patient Retirement Date: _____ Spouse Retirement Date: _____

Patient Employer: _____ Spouse Employer: _____

In regards to the care the patient is scheduled for please answer the following questions:

Are you entitled to Federal Black Lung benefits? ☐ YES ☐ NO

Are services to be covered by a Public Health Service or Research Program? ☐ YES ☐ NO

If yes, what is the name of the program? _____

Is this illness/injury to be covered by a workman's compensation claim? ☐ YES ☐ NO

If yes, please provide the claim information, including the adjustor: _____

_____

Is this illness/injury the result of a non-work related accident? ☐ YES ☐ NO

If yes, please provide the accident information, including the date/time and nature of the accident:

_____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____