

# Medicare Secondary Payor Development Form

Facility Name <b>GCAM</b>	COID <b>19563</b>	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date
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Patient's Name	Account No.	Medicare No.
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**You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.**

<p><b>Does the patient have an HMO policy?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of HMO: _____ _____</p> <p><b>Does the HMO replace Medicare?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, the HMO will be primary. If No, it will be secondary.</p> <p><b>Is this patient an inpatient?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>Was the patient given Important Message?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If No, why not? _____</p>	<p><b>Has patient been an Inpatient in a health care facility within the last 60 days?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of facility: _____ _____</p> <p><b>Has the patient had any outpatient medical services in the last 72 hours?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, name, address and phone of facility: _____ _____</p>
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<p>1. Are you receiving Black Lung (BL) Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date benefits began: _____ If Yes, BL is Primary only for claims related to BL.</p> <p>2. Are the services to be paid by a government program such as a research grant? <input type="checkbox"/> No <input type="checkbox"/> Yes; Government program will pay primary benefits for these services.</p> <p>3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? <input type="checkbox"/> No <input type="checkbox"/> Yes; DVA is primary for these services.</p> <p>4. Was the illness/injury due to work related accident or condition? <input type="checkbox"/> No; <b>Go to Question 5.</b> <input type="checkbox"/> Yes; Date of injury/illness: _____ Name, address and phone of Workers Compensation Plan: _____ _____ Policy or ID Number: _____ Name, address and phone number of your employer: _____ _____ If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. <b>Go to Question 8.</b></p> <p>5. Was the illness/injury due to a non-work related accident? <input type="checkbox"/> No; <b>Go to Question 8.</b> <input type="checkbox"/> Yes; Date of accident: _____</p> <p>6. What type of accident caused the illness/injury? <input type="checkbox"/> Automobile <input type="checkbox"/> Non-Automobile Name, address and phone of no-fault or liability insurer: _____ _____ Insurance Claim Number: _____ No-Fault insurer is Primary payor only for those claims related to the accident. <b>Go to Question 8.</b> <input type="checkbox"/> Other (explain) _____</p>	<p>7. Was another party responsible for this accident? <input type="checkbox"/> No; <b>Go to Question 8.</b> <input type="checkbox"/> Yes; Provide name, address and phone of any liability insurer: _____ _____ Insurance claim number: _____ If yes, liability insurer is Primary only for those claims related to the accident. <b>Go to Question 8.</b></p> <p>8. Are you entitled to Medicare based on: <input type="checkbox"/> Age; <b>Go to Questions 9 – 12.</b> <input type="checkbox"/> Disability; <b>Go to Questions 13 – 16.</b> <input type="checkbox"/> ESRD; <b>Go to Questions 17 – 23.</b></p> <p>9. Are you currently employed? <input type="checkbox"/> No; Date of retirement: _____ <input type="checkbox"/> Yes; Provide name, address and phone of your employer: _____ _____</p> <p>10. Is your spouse currently employed? <input type="checkbox"/> No; Date of retirement: _____ <input type="checkbox"/> Yes; Provide name, address and phone of spouse's employer: _____ _____</p> <p>If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer. <b>Do not proceed any further.</b> If yes to questions 9 or 10, go to questions 11 and 12.</p> <p>11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? <input type="checkbox"/> No; <b>Stop. Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.</b> <input type="checkbox"/> Yes</p>
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**Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare.**

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Patient's Name _____	Account No. _____	Medicare No. _____
12. Does the employer that sponsors your GHP employ 20 or more employees? <input type="checkbox"/> No; <b>Stop. Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 - 7.</b> <input type="checkbox"/> Yes; <b>Stop. Group Health Plan is Primary. Obtain the following information.</b> Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	17. Do you have group health plan (GHP) coverage? <input type="checkbox"/> No: <b>Stop. Medicare is Primary.</b> <input type="checkbox"/> Yes; Provide name, address and phone of GHP: _____ _____ Policy ID Number _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____ Name, address and phone of employer, if any from which you received GHP coverage: _____ _____	
13. Are you currently employed? <input type="checkbox"/> No; Date of Retirement _____ <input type="checkbox"/> Yes; Provide name, address and phone of your employer: _____ _____	18. Have you received a kidney transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date of Transplant: _____	
14. Is a family member currently employed? <input type="checkbox"/> No <input type="checkbox"/> Yes; Provide name, address and phone of employer: _____ _____ <i>If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1-4 or 5-7. Do not proceed any further.</i> <i>If Yes to questions 13 or 14, go to question 15 and 16.</i>	19. Have you received maintenance dialysis treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date dialysis began: _____ If you participated in self dialysis training program, provide date training started: _____	
15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment? <input type="checkbox"/> No; <b>Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</b> <input type="checkbox"/> Yes	20. Are you within the 30 month coordination period? <input type="checkbox"/> No; <b>Stop. Medicare is Primary.</b> <input type="checkbox"/> Yes	
16. Does the employer that sponsors your GHP, employ 100 or more employees? <input type="checkbox"/> No; <b>Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</b> <input type="checkbox"/> Yes; <b>Stop. Group Health Plan is Primary. Obtain the following information:</b> Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability? <input type="checkbox"/> No; <b>Stop. GHP is Primary during the 30 month coordination period.</b> <input type="checkbox"/> Yes	
22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD? <input type="checkbox"/> No; <i>Initial entitlement based on age or disability.</i> <input type="checkbox"/> Yes; <b>Stop. GHP continues to pay Primary during the 30<sup>th</sup> month coordination period.</b>	23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)? <input type="checkbox"/> No; <i>Medicare continues to pay Primary.</i> <input type="checkbox"/> Yes; <i>GHP continues to pay Primary during the 30 month coordination period.</i>	
I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.		
X _____ Patient or Representative / Relationship	X _____ Witness	_____ Date