Rehabilitation Center

Medicare Questionaire

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name:____ Date of Birth:___________________________

Physician:____

SECTION I
Select the ONE statement that is true for you:

- ☐ I am over 65 and married…**Proceed to section II**
- ☐ I am over 65 and not married (includes widowed)…**Proceed to section III**
- ☐ I am under 65, disabled and currently employed…**Proceed to section IV**
- ☐ I am under 65, disabled and unemployed…
  Disability Date:__________________**Proceed to section IV**

SECTION II
Select the ONE statement that is true for you:

- ☐ My spouse and I are both fully retired
  The date of my retirement:_____________________________
  The date of my spouse's retirement:_____________________…**Proceed to section V**
- ☐ **I work** full or part-time (my spouse is retired) for a company with:
  - ☐ LESS than 20 employees…**Proceed to section V**
  - ☐ MORE than 20 employees…**Proceed to section IV**
- ☐ **My spouse works** full or part-time (I am retired) for a company with:
  - ☐ LESS than 20 employees…**Proceed to section V**
  - ☐ MORE than 20 employees…**Proceed to section IV**

SECTION III
Select the one statement that is true for you:

- ☐ I am fully retired…
  The date of my retirement:_____________________________…**Proceed to section V**
- ☐ I work full or part-time for a company with:
  - ☐ LESS than 20 employees…**Proceed to section V**
  - ☐ MORE than 20 employees…**Proceed to section IV**

SECTION IV
Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

I have health care coverage through my employer: ☐ NO ☐ YES
I have health coverage through someone else: ☐ NO ☐ YES
IF YES, list name of guardian and relationship:____

Proceed to Section V

Continued on other side…

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SECTION V

Is this visit related to an injury due to a fall?

- ☐ YES – Did the accident occur in… ☐ your home ☐ public location ☐ other
  Date of accident:________________________

OR…

Is this visit related to an illness/injury due to an automobile accident?

- ☐ YES – Date of accident:_________________
- ☐ NO **Proceed to Section VI**

SECTION VI

Indicate which statements apply to you:

- ☐ I am entitled to Worker's Compensation for this service.
- ☐ I am entitled to Black Lung benefits.
- ☐ I am entitled VA *(Veterans's Administration)* benefits.
- ☐ I am entitled ESRD *(End Stage Renal Disease)* benefits.
- ☐ I am entitled COBRA benefits.
- ☐ I am entitled to other Federal benefits such as UMWA *(United Mine Workers of America)*, government research programs, or hospice.

  Please explain:____

  ____

Patient Signature_______________________________________ Date__________________________________

Staff Signature____ Date__________________________________