Medicare Secondary Payer (MSP) Form

Patient Name: _____

Medicare Number: _____

Provider #: _____

Date: _____

1. Do you receive Veteran's benefits? Yes □ No □
2. Are you receiving benefits under the Black Lung Program? Yes □ No □

   If yes, date benefits began _____

   If yes, are the services you will be receiving related to a non-black lung condition?

   Yes □ No □
3. Was this injury/illness due to a work related accident/condition? Yes □ No □

   If yes, date of injury/illness _____
4. Was this injury/illness related to an automobile accident? Yes □ No □

   If yes, date of accident _____
5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? Yes □ No □

   If yes, please provide: Attorney's name: _____

   Address: _____

   Phone number: _____
6. Are you entitled to Medicare based on: □ Age (65 & over) – go to question 7

   □ Disability – go to question 7

   □ End Stage Renal Disease

   Do you have group health plan (GHP) coverage? Yes □ No □

   Are you within the 30-month coordination period? Yes □ No □
7. Are you currently employed? Yes □ No □ Date of retirement _____

   a) Is your spouse currently employed? Yes □ No □ Date of retirement _____

   b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current(or former) employment? Yes □ No □

   c) Does the employer that sponsors your GHP employ 20 or more employees?

   Yes □ No □

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co: _____Address:_____
Policy/Cert #: _____
Group name & #: _____

Patient's name: _____
Responsible party relationship: _____