Physical Therapy/Health & Wellness
GERIL THERAPY
Elevating Your Quality Of Life

Medicare Secondary Payer (MSP) Form

Patient Name: _____ **Clinic Name:** _____

Medicare Number: _____ **Provider #:** _____

Account Number: _____ **Date:** _____

1. Has the Department of Veteran's Affairs (DVA) authorized and agreed to pay for care at this facility? Yes ☐ No ☐
2. Are the services to be paid by a government program such as a research grant? Yes ☐ No ☐
3. 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 ☐
4. Was this injury/illness due to a work related accident/condition? Yes ☐ No ☐
   If yes, date of injury/illness _____
   Name/address of WC plan _____ Policy/ID number: _____
5. Was this injury/illness related to an automobile accident? Yes ☐ No ☐
   If yes, date of accident _____
   Name/address no-fault or liability carrier _____ Claim number: _____
6. 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 # _____
7. Are you entitled to Medicare based on:
   ☐ Age (65 & over) – go to question 8 ☐ Disability – go to question 8 ☐ End Stage Renal Disease
   Do you have group health plan (GHP) coverage? Yes ☐ No ☐ If yes, complete GHP info
   Have you received a kidney transplant? Yes ☐ Date: _____ No ☐
   Have you received maintenance dialysis treatments? Yes ☐ Date started: _____ No ☐
   Are you within the 30-month coordination period? Yes ☐ No ☐ If yes, complete GHP info
   Are you within the 30-month coordination period? Yes ☐ No ☐
8. Are you currently employed? Yes ☐ No ☐ Date of retirement _____ Never Employed ☐
   a) Is your spouse currently employed? Yes ☐ No ☐ Date of retirement _____ Never Employed ☐
   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 any part of question #7 above, please complete the following information:

Employer name: _____
Address: _____
Policy/Cert #: _____
Group name & #: _____
Relationship to patient: _____

Patient's signature Date

Responsible party Relationship