

# 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 7
  - Disability – go to question 7
  - 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