ARCHBOLD MEDICAL GROUP

Medicare Secondary Payer Questionnaire

Medicare requires physician offices to gather insurance information by asking Medicare beneficiaries, or their representative, about insurance coverage at every office visit.

Please write the patient's name as it appears on the Medicare card: _____

Medicare Entitlement

1. Is the patient 65 years old or older? ☐ Yes ☐ No

2. Is the patient less than 65 years old, but has a disability? ☐ Yes ☐ No

3. Is the patient less than 65 years old, but has End Stage Renal Disease (kidney disease)? ☐ Yes ☐ No

   If the patient is on dialysis complete these questions:

   a. Has the patient been on dialysis longer than 30 months? ☐ Yes ☐ No
   b. What date did the patient start dialysis? _____
   c. If the patient participated in self-dialysis training, what was the date? _____
   d. If patient received kidney transplant, what was the date? _____

Retirement Information

4. Is the patient retired? ☐ Yes ☐ No. If yes, what is the patient's retirement date? _____

5. Is the patient's spouse retired? ☐ Yes ☐ No. If yes, what is the spouse's retirement date? _____

Employment Information

6. Is the patient currently employed? ☐ Yes ☐ No.

7. Is the patient's spouse currently employed? ☐ Yes ☐ No.

   a. Is the patient covered by any other health insurance/group health plan? ☐ Yes ☐ No
   b. What is the name of your health insurance/group health plan? _____

   The insurance card will need to be scanned into your record at every visit. Please take your insurance card to the front desk for them to scan into your record.

Veteran's Coverage

8. Has the Veteran's Administration authorized and agreed to pay for this visit at this practice? ☐ Yes ☐ No

   If yes, your physician's office will need to obtain an authorization number for your treatment.

Liability Insurance

9. Is the patient's illness/injury accident or work related? ☐ Yes ☐ No

10. Is there liability or worker's compensation insurance to cover this illness/injury? ☐ Yes ☐ No
    a. What is the insurance claim number? _____
    b. Date of Accident: _____
    c. What is the liability insurance company's name? _____
    d. What is the liability insurance company's phone number? _____
    e. What is the liability insurance company's address: _____
    _____

Information provided by: _____ Date: _____

Office Use Only: Additional Comments