NATURE COAST PHYSICAL THERAPY & REHAB

MEDICARE SECONDARY PAYER QUESTIONAIRE

Person Giving Information:_____ Relationship to Patient:_____

Patient Name:_____ HIC Number:_____

DOB:_____ Sex: ☐ Male ☐ Female

Basis for Patient Entitlement to Medicare:

☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)

A. GROUP HEALTH PLAN INFORMATION

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

If No: Retirement date of Patient:_____
Retirement date of Spouse:_____

If you answered NO, go to section B. If you answered YES, continue below:

Which person is employed? ☐ Patient ☐ Spouse

Are there (choose one): ☐ Less than 20 employees ☐ More than 100 employees

Is employee actively working? ☐ Yes ☐ No

Insurance Company:_____ Policy Number:_____
Plan Name:_____ Plan ID Number:_____

Is the patient employed? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

Employer Name:_____
Employer Address:_____
City:_____ State:_____ Zip Code:_____

B. AUTOMOBILE, NO FAULT, OR LIABILITY INSURANCE INFORMATION

Is the illness/injury due to an accident? ☐ Yes ☐ No

If you answered NO, go to section C. If you answered YES, continue below:

Type of non-work-related accident: ☐ Automobile ☐ Other (describe)_____

Date of Accident: _____

Insurance situation: ☐ Liable ☐ Not Liable

Name of Policy Holder:_____
Address of Policy Holder:_____
Policy Number or Claim Identification Number:_____
Name of Insurance Company:_____
Address:_____ Phone:_____
Name of Patient's Legal Representative for this case, if any:_____
Phone Number of Legal Representative:_____

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C. WORKER'S COMPENSENATION INSURANCE INFORMATION

Was the patient involved in a work-related accident? ☐ Yes ☐ No

If you answered NO, go to section D. If you answered YES, continue below:

Date of Accident:_____

Is the patient working? ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Employer Name:_____

Employer Address:_____

Name of Worker's Compensation Agency:_____

Insurance Claim or Policy Number:_____

Caseworker/Contact Person:_____ Phone:_____

Has the case been settled? ☐ No ☐ Yes (Date settled)_____

Name of Patient's Legal Representative for this case, if any:_____

Phone Number of Legal Representative:_____

D. VETERAN'S ADMINISTRATION (VA) AUTHORIZATION INFORMATION

Does the patient have a VA fee service card? ☐ Yes ☐ No

Has the VA issued authorization for these services? ☐ Yes ☐ No

Does the patient authorize you to bill the VA? ☐ Yes ☐ No

E. BLACK LUNG INSURANCE INFORMATION

Is the patient entitled to benefits under the Department of Labor's Black Lung Program?

☐ Yes ☐ No

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? ☐ Yes ☐ No

By signing below, I acknowledge that the above information is accurate at the time of my signature.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date