Campus Surgery Center
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# Medicare Secondary Payer Questionnaire
## (Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung ____No ____Yes
Research Grant ____No ____Yes
Veteran Affairs ____No ____Yes

2. Was the illness/injury due to a work related accident/condition?

_____ No _____ Yes Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

_____ No _____ Yes Date of accident: _____

What type of accident caused the illness/injury?

_____ Automobile_____ Non-automobile

4. Are you entitled to Medicare based on:

_____ Age _____ Disability _____ End Stage Renal Disease

5. Are you currently employed?

_____ No _____ Yes

6. Is your spouse currently employed?

_____ No _____ Yes

7. Do you have health insurance sponsored through your own or spouse's employer?

_____ No _____ Yes

8. Does the employer that sponsors your insurance plan employ 20 or more employees?

_____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?
(Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____

Please Print Name:_____