Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date

Patient's Name	Account No.	Medicare No.

Complete personal information blanks at top of form. Complete questions 1-5 and then follow instructions to see if you can skip to question 8. Once question 8 is complete follow the designated color block to the final section to complete. Complete appropriate color blocked section until you reach "**Stop Here**". **Sign & date the form.**

Does the patient have an HMO policy? ☐ No ☐ Yes

If Yes, name, address and phone of HMO:

_____

_____

Does the HMO replace Medicare? ☐ No ☐ Yes

If Yes, the HMO will be primary. If No, it will be secondary.

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ No
   - ☐ Yes; Date benefits began: _____

   If Yes, BL is Primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant?
   - ☐ No
   - ☐ Yes; *Government program will pay primary benefits for these services.*

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   - ☐ No
   - ☐ Yes; *DVA is primary for these services.*

4. Was the illness/injury due to work related accident or condition?
   - ☐ No; **Go to Question 5.**
   - ☐ Yes; Date of injury/illness: _____

   Name, address and phone of Workers Compensation Plan:

   _____

   _____

   _____

   Policy or ID Number:

   Name, address and phone number of your employer:

   _____

   _____

   If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Date of accident: _____

6. What type of accident caused the illness/injury?
   - ☐ Automobile ☐ Non-Automobile

   Name, address and phone of no-fault or liability insurer:

   _____

   _____

   _____

   Insurance Claim Number: _____

   No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**

   ☐ Other (explain) _____

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

_____

_____

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

_____

_____

7. Was another party responsible for this accident?
   - ☐ No; **Go to Question 8.**
   - ☐ Yes; Provide name, address and phone of any liability insurer:

   _____

   _____

   _____

   Insurance claim number: _____

   If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:
   - ☐ Age; **Go to Questions 9 – 12.**
   - ☐ Disability; **Go to Questions 13 – 16.**
   - ☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?
   - ☐ No; Date of retirement: _____
   - ☐ Yes; Provide name, address and phone of your employer:

   _____

   _____

10. Is your spouse currently employed?
    - ☐ No; Date of retirement: _____
    - ☐ Yes; Provide name, address and phone of spouse's employer:

    _____

    _____

    If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1-4 or 5-7 then Medicare is NOT primary payer.
    Do not proceed any further.
    If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
    - ☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*
    - ☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

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Patient's Name | Account No. | Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
- ☐ No; **Stop.** M*edicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
- ☐ Yes; **Stop.** Group Health Plan is Primary. Obtain the following information.

Name, address and phone of GHP:

_____

_____

_____

Policy ID Number _____

Group ID Number: _____

Name of Policy Holder _____

Relationship to Patient _____

Stop Here *(Signature required at bottom)*

13. Are you currently employed?
- ☐ No; Date of Retirement _____
- ☐ Yes; Provide name, address and phone of your employer:

_____

_____

_____

14. Is a family member currently employed?
- ☐ No
- ☐ Yes; Provide name, address and phone of employer:

_____

_____

_____

If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
- ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
- ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

Name, address and phone of GHP:

_____

_____

_____

Policy ID Number: _____

Group ID Number: _____

Name of Policy Holder _____

Relationship to Patient _____

Stop Here *(Signature required at bottom)*

17. Do you have group health plan (GHP) coverage?
- ☐ No: **Stop.** *Medicare is Primary.*
- ☐ Yes; Provide name, address and phone of GHP:

_____

_____

_____

Policy ID Number: _____

Group ID Number: _____

Name of Policy Holder _____

Relationship to Patient _____

Name, address and phone of employer, if any from which you received GHP coverage:

_____

_____

_____

18. Have you received a kidney transplant?
- ☐ No
- ☐ Yes; Date of Transplant: _____

19. Have you received maintenance dialysis treatments?
- ☐ No
- ☐ Yes; Date dialysis began: _____

If you participated in self dialysis training program, provide

Date training started: _____

20. Are you within the 30 month coordination period?
- ☐ No; **Stop.** *Medicare is Primary.*
- ☐ Yes

21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
- ☐ No; **Stop.** *GHP is Primary during the 30 month coordination period.*
- ☐ Yes

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
- ☐ No; *Initial entitlement based on age or disability.*
- ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
- ☐ No; *Medicare continues to pay Primary.*
- ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

Stop Here *(Signature required at bottom)*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X _____ X _____ X _____

Patient or Representative / Relationship | Witness | Date