

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.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.
<p>12. Does the employer that sponsors your GHP employ 20 or more employees?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 - 7.</p> <p><input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information.</p> <p>Name, address and phone of GHP:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Policy ID Number _____</p> <p>Group ID Number: _____</p> <p>Name of Policy Holder _____</p> <p>Relationship to Patient _____</p> <p>Stop Here (Signature required at bottom)</p>	<p>17. Do you have group health plan (GHP) coverage?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary.</p> <p><input type="checkbox"/> Yes; Provide name, address and phone of GHP:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Policy ID Number: _____</p> <p>Group ID Number: _____</p> <p>Name of Policy Holder _____</p> <p>Relationship to Patient _____</p> <p>Name, address and phone of employer, if any from which you received GHP coverage:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>13. Are you currently employed?</p> <p><input type="checkbox"/> No; Date of Retirement _____</p> <p><input type="checkbox"/> Yes; Provide name, address and phone of your employer:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>18. Have you received a kidney transplant?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes; Date of Transplant: _____</p>	
<p>14. Is a family member currently employed?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes; Provide name, address and phone of employer:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><i>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.</i></p>	<p>19. Have you received maintenance dialysis treatments?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes; Date dialysis began: _____</p> <p>If you participated in self dialysis training program, provide Date training started: _____</p>	
<p>15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</p> <p><input type="checkbox"/> Yes</p>	<p>20. Are you within the 30 month coordination period?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary.</p> <p><input type="checkbox"/> Yes</p>	
<p>16. Does the employer that sponsors your GHP, employ 100 or more employees?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</p> <p><input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information:</p> <p>Name, address and phone of GHP:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Policy ID Number: _____</p> <p>Group ID Number: _____</p> <p>Name of Policy Holder _____</p> <p>Relationship to Patient _____</p> <p>Stop Here (Signature required at bottom)</p>	<p>21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?</p> <p><input type="checkbox"/> No; Stop. GHP is Primary during the 30 month coordination period.</p> <p><input type="checkbox"/> Yes</p>	
<p>16. Does the employer that sponsors your GHP, employ 100 or more employees?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</p> <p><input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information:</p> <p>Name, address and phone of GHP:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Policy ID Number: _____</p> <p>Group ID Number: _____</p> <p>Name of Policy Holder _____</p> <p>Relationship to Patient _____</p> <p>Stop Here (Signature required at bottom)</p>	<p>22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?</p> <p><input type="checkbox"/> No; Initial entitlement based on age or disability.</p> <p><input type="checkbox"/> Yes; Stop. GHP continues to pay Primary during the 30th month coordination period.</p>	
<p>16. Does the employer that sponsors your GHP, employ 100 or more employees?</p> <p><input type="checkbox"/> No; Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 - 4 or 5 - 7.</p> <p><input type="checkbox"/> Yes; Stop. Group Health Plan is Primary. Obtain the following information:</p> <p>Name, address and phone of GHP:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Policy ID Number: _____</p> <p>Group ID Number: _____</p> <p>Name of Policy Holder _____</p> <p>Relationship to Patient _____</p> <p>Stop Here (Signature required at bottom)</p>	<p>23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?</p> <p><input type="checkbox"/> No; Medicare continues to pay Primary.</p> <p><input type="checkbox"/> Yes; GHP continues to pay Primary during the 30 month coordination period.</p> <p>Stop Here (Signature required at bottom)</p>	
<p>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.</p>		
X _____	X _____	X _____
Patient or Representative / Relationship	Witness	Date