

Medicare Secondary Payer (MSP) Form

**Professional
Rehabilitation
Services**

Patient Name _____

1. Do you receive Veteran's benefits? Yes No
2. Are you receiving benefits under the Black Lung Program? Yes No
If yes, date benefits began: _____ / _____ / _____
If yes, are the services you will be receiving related to a non-black lung condition? Yes No
3. Was this injury/illness due to a work related accident/condition? Yes No
If yes, date of accident: _____ / _____ / _____
4. Was this injury/illness related to an automobile accident? Yes No
If yes, date of accident: _____ / _____ / _____
5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? Yes No
If yes please provide:
Attorney's Name: _____
Address: _____
Phone Number: _____
6. Are you entitled to Medicare based on:
 Age (65&over) – Go to question 7
 Disability – Go to question 7
 End Stage Renal Disease
Do you have group health plan (GHP) coverage? No Yes
Are you within the 30-month coordination period? No Yes
7. Are you currently employed? Yes No
Date of retirement: _____ / _____ / _____
 - a) Is your spouse currently employed? Yes No
Date of retirement: _____ / _____ / _____
 - b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current or former employment? Yes No
 - c) Does the employer that sponsors your GHP employ 20 or more employees? Yes No
8. Are you currently receiving any type of Home Health Care? Yes No
Agency Name: _____
Phone Number: _____
9. Are you currently enrolled in Hospice? Yes No

If you answered Yes to questions 3, 4, or 7 above, please complete the following information:

Insurance Company: _____
Address _____
Policy ID Number: _____
Group Name and Number: _____

Patient Signature

Date

Responsible Party

Relationship