Medicare Secondary Payer (MSP) Form

Use when Medicare is Secondary Insurance for patient for reasons indicated below.

Patient Name_____ **Date of Birth** _____

Please answer all questions that apply to why your Medicare policy is secondary.

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 (Group Health Plan) as primary coverage based on your own or
       a spouse's current or former employment? .... ☐Yes ☐No
       c) Does the employer that sponsors your Group Health Plan employ 20 or more employees?......................... ☐Yes ☐No

8. Are you currently receiving any type or 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

**Note FD – You must check Medicare online for the reason code and make sure it matches up when imputing secondary insurance information in Clinicient. This can be found by logging into Medicare like you normally do for deductible etc… there is a tab that says (MSP) that is where you will find the reason code. Make sure enter, print and scan into Clinicient. (See samples)

This has been completed**: FD Initials: _____**