DIAGNOSTIC IMAGING CENTERS, P.A.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

FOR USE BY ALL MEDICARE OUTPATIENTS

Patient Name	MPI #	Date of Service

1. Are you entitled to Medicare based on:
   Age (65 & over) ❑Yes ❑No
   Disability ❑Yes ❑No
   End Stage Renal Disease ❑Yes ❑No
   Do you have group health plan (GHP) coverage? ❑Yes ❑No
   Are you within the 30 month coordination period? ❑Yes ❑No

2. Are you currently employed? ❑Yes ❑No Retirement date_____
   a. Is your spouse employed? ❑Yes ❑No Retirement date_____
   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

3. Was this injury/illness due to a work related accident/condition? ❑Yes ❑No
   If yes, date of injury/illness_____

4. Was this injury/illness due to an automobile accident? ❑Yes ❑No
   If yes, date of injury/illness_____

5. Was this injury/illness related to an accident in which you intend to file a liability suit or is litigation pending? ❑Yes ❑No

6. Do you receive Veteran's benefits? ❑Yes ❑No

7. 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

If you have answered yes to questions #2, #3 or #4 above, please complete the following information:

Insurance Company _____

Address_____

Policy/Cert #_____

Group Name & #_____

_____ _____

Patient/spouse, or family member signature Date