PROactive
PHYSICAL THERAPY SPECIALISTS

Medicare Secondary Payer (MSP) Form

Patient Name: _____Acct#: _____

Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.

1. Do you receive Veteran's benefits? ☐ Yes ☐ No
2. Are the services to be paid by a government research program? ☐ Yes ☐ No
2. Are you receiving benefits under the Black Lung Program? ☐ Yes ☐ No
   If yes, date benefits began _____
   Black lung is primary payer only for claims related to black lung
3. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness _____; *Please provide the WC information*
4. Was the 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 liability suit or litigation pending? ☐ Yes ☐ No *If yes, please provide the Attorney's information*

(If answered YES to any of the questions above Medicare is the secondary payer)

6. Are you entitled to Medicare based on:
   ☐ Age (65 & over)—go to question 7
   ☐ Disability—go to question 8
   ☐ End Stage Renal Disease—if **yes to both questions below-group health plan (GHP) is primary**
   1. Do you have group health plan coverage? ☐ Yes ☐ No
   2. Are you within the 30-month coordination period? ☐ Yes ☐ No

7. Are you currently employed? ☐ Yes ☐ No - Date of retirement _____
   a. Is your spouse employed? ☐ Yes ☐ No - Date of retirement _____
   b. Do you have a GHP as primary coverage based on your own or spouse's current employment? ☐ Yes ☐ No
   c. Does the employer that sponsors the GHP employ <u>20 or more</u> employees? ☐ Yes ☐ No

If you OR your spouse is currently employed and answered YES to BOTH b and c, GHP is primary, please provide your insurance information

8. Are you currently employed? ☐ Yes ☐ No Date of retirement _____
   a. Is your spouse/family member employed? ☐ Yes ☐ No
   b. Do you have a GHP as primary coverage based on your own or spouse's or family member's current employment? ☐ Yes ☐ No
   c. If you have group health coverage, does employer that sponsors the GHP employ <u>over 100 or more</u> employees? ☐ Yes ☐ No

If you have GHP coverage based on your or spouse's or family member's current employment and answered YES to BOTH b and c, GHP is primary, please provide your insurance information.

_____
Signature of Patient/Representative Date

_____
Relationship to patient