Who Provided The Information:_________________________________
Date Information was Collected:______________________________

M E D I C A R E   Q U E S T I O N A I R E

PART I

1. Are you receiving Black Lung (BL)Benefits?
   __ YES; Date benefits began: MM/DD/CCYY ___
   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

   If YES, Select insurance plan ____ Black Lung (Plan # 0830)
   Date benefits began is effective date for BL plan.

   __ NO. CONTINUE TO NEXT QUESTION.

2. Are the services to be paid by a government program such as a research grant?
   __ YES; Government Program will pay primary benefits for these services.

   __ NO. CONTINUE TO NEXT QUESTION.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   __ YES; DVA IS PRIMARY FOR THESE SERVICES.

   __ NO. CONTINUE TO NEXT QUESTION.

4. Was the illness/injury due to a work related accident/condition?
   __ YES; Date of injury/illness: MM/DD/CCYY ___

   If YES, select appropriate workman's comp plan

   Name and address of WC plan:

   _____
   _____
   _____

   Policy or identification number___
   Name and address of your employer:

   _____
   _____
   _____
   WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

__NO. GO TO PART II.

PART II

1. Was illness/injury due to a non-work related accident?
   __ YES; Date of accident: MM/DD/CCYY ___
   IF YES, GO TO QUESTION #2.

   __ NO. GO TO PART III

2. What type of accident caused the illness/injury?
   __ Automobile
   __ Non-automobile
   Name and address of no-fault or liability insurer:

   ______
   ______
   ______
   Insurance claim number___
   NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.   GO TO PART III.
   __ other.

3. Was another party responsible for this accident?
   __ YES;

   Name and address of any liability insurer:

   ____
   ____
   ____
   Insurance claim number____
   LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

   __ NO. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:
   __ Age. GO TO PART IV.
   __ Disability. GO TO PART V.
   __ ESRD. GO TO PART VI.

PART IV - AGE

1. Are you currently employed?
__ YES;

Name and address of your employer:

_____
_____
_____

__ NO. DATE OF RETIREMENT: MM/DD/CCYY ___
__ NO. NEVER EMPLOYED

2. Is your spouse currently employed?
__ YES;
Name and address of spouse's employer:

_____
_____
_____

__ NO. DATE OF RETIREMENT: MM/DD/CCYY ___
__ NO. NEVER EMPLOYED

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 & 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan(GHP)coverage based on your own, or a spouse's current employment?
__ YES.
__ NO. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.
4. Does the employer that sponsors your GHP employ 20 or more employees?
__ YES. STOP. GROUP HEALTH PLAN(GHP) IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.
Name and address of GHP:

_____
_____
_____
Policy identification number(this number is sometimes referred to as the health insurance benefit package number)___
Group identification number___
Membership number(prior to the Health Insurance Portability and Accountability Act(HIPAA), this number was frequently the individual's

Social Security Number(SSN); it is the unique identifier assigned to the policyholder/patient)___
Name of policy holder/named insured___
Relationship to patient___
__NO. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V - Disability

1. Are you currently employed?
__ YES; Name and address of employer: ______________
__ NO
. DATE OF RETIREMENT: MM/DD/CCYY ___
__ NO. NEVER EMPLOYED.

2. If married, is your spouse currently employed?
__ YES; Name and address of your spouse's employer: ______________
__ NO
. DATE OF RETIREMENT: MM/DD/CCYY ___
__ NO. NEVER EMPLOYED. IF PATIENT ANSWERS "NO" TO BOTH QUESTIONS 1 & 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP)coverage based on your own, or a family member's, current employment?
__ YES.
__ NO . STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

4. Are you covered under the group health plan of a family member other than your spouse?
__ YES.
Name and address of your family member's employer: _____________
__NO.

5. Does the employer that sponsors the GHP employ 100 or more employees?
__ YES. STOP. GROUP HEALTH PLAN IS PRIMARY.
OBTAIN THE FOLLOWING INFORMATION.
Name and address of GHP: ______________
Policy identification number(this number is sometimes referred to as the health insurance benefit package number)___
Group identification number___
Membership number(prior to HIPAA, this number was frequently the indiv idual's SSN; it is the unique identifier assigned to the policyholder/patient)___

Name of policy holder/named insured___
Relationship to the patient___
__ NO. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI - ERSD

1. Do you have group health plan(GHP) coverage?
If YES, name and address of GHP: _______________
Policy identification number(this number is sometimes referred to as the health insurance benefit package number)___
Group identification number___
Membership number(prior to HIPAA, this number was frequently the indiv idual's SSN; it is the unique identifier assigned to the polic yholder/patient)___
Name of policy holder/named insured___
Relationship to the patient___
Name and address of employer,if any, from which you receive GHP coverage:
____
__ NO. STOP. MEDICARE IS PRIMARY.

2. Have you received a kidney transplant?
__ YES; Date of transplant: MM/DD/CCYY ___
__ NO.

3. Have you received maintenance dialysis treatments?
__ YES; Date dialysis began: MM/DD/CCYY ___

If you participated in a self dialysis training program, provide date training started: MM/DD/CCYY ___
__ NO.

4. Are you within the 30 month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)
__ YES.
__ NO. STOP. MEDICARE IS PRIMARY.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

__ YES.
__ NO.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
__ YES; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
__ NO. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
__ YES. STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
__ NO. MEDICARE CONTINUES TO PAY PRIMARY.