COLTMAN & BAUGHMAN
Sports and Orthopedic Physical Therapy

Medicare Secondary Payer Form

Please answer ALL questions.

PART I:

1. Are you receiving Black Lung Benefits?
   _____Yes _____No If so, date benefits began ___/___/_____

2. Are the services to be paid by a government research program? _____Yes _____No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   _____Yes _____No

4. Was the illness/injury due to a work-related accident/condition? _____Yes _____No
   If so, date of illness/injury ___/___/_____

PART II:

1. Was the illness/injury due to a non-work related incident? _____Yes _____No

2. Is no-fault insurance available? *(No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)*
   _____Yes _____No

3. Is liability insurance available? *(Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)*
   _____Yes _____No

PART III:

1. You are entitled to Medicare based on: Age____ Disability____ End-Stage Renal Disease (ESRD)____

PART VI: Age

1. Are you or your spouse currently employed? _____Yes _____No

2. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
   _____Yes _____No

3. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?
   _____Yes _____No

4. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 20 or more employees?
   _____Yes _____No

PART V: Disability

1. Are you or your spouse currently employed? _____Yes _____No

2. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

_____Yes _____No

3. Are you covered under the GHP of a family member other than your spouse? _____Yes _____No

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP, employ 100 or more employees?
   _____Yes _____No

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
   _____Yes _____No

6. If you have a GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ more than 100 employees?
   _____Yes _____No

PART VI: ESRD (End-Stage Renal Disease)

1. Do you have group health plan (GHP) coverage? _____Yes _____No

2. Have you received a kidney transplant? _____Yes _____No If so, date of transplant: ___/___/_____

3. Have you received maintenance dialysis treatments? _____Yes _____No
   If so, date dialysis began: ___/___/_____
   If you participated in a self-dialysis training program, provide date training started:
   ___/___/_____

4. Are you within the 30-month coordination period that starts ___/___/_____? *(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 forth 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).*

5. Are you entitled to Medicare on the basis of either ESRD and Age or ESRD and Disability?
   _____Yes _____No

6. Was your initial enrollment in Medicare (including simultaneous or dual entitlement) based on ESRD?
   _____Yes _____No

7. Does the working aged or disability MSP provision apply (i.e. is the GHP already primary based on age or disability entitlement)?
   _____Yes _____No

Signature:_____ Date:_____

Witness:_____ Date:_____

90 Day Review- All of the above is still accurate

Patient Signature:_____ Date:_____
Patient Signature:_____ Date:_____
Patient Signature:_____ Date:_____