HSHS St. John's Hospital

MEDICARE SECONDARY PAYOR REVIEW

Date: _____

Patient name: _____ Medicare #: _____ Part A: _____ Part B: _____

Person supplying information: _____ Relationship to patient: _____

1. **Patient**

A. Are you employed ? ☐ Yes ☐ No **(If yes, Cond.Code 09)**
If no, enter retirement date: _____ **(Occur Code 18)**
If yes, are you covered by an Employer Group Health Plan of 20 or more employees ? ☐ Yes ☐ No **(10)**
Name of employer _____
Mailing address _____
City_____ State _____ Zip ___ _____
Name of insurance _____
Billing address _____
City _____ State _____ Zip _____
Policy # _____ Name of policy holder _____
Relation to patient _____ Group ID # _____

B. Is spouse employed by an employer of 20 or more employees ? ☐ Yes ☐ No **(If yes, Cond.Code 09)**
If no, enter retirement date: _____ **(Occur Code 19)**
Is the patient covered by the spouse's EGHP ? ☐ Yes ☐ No **(10)**
If yes, name of employer _____
Mailing address _____
City _____ State _____ Zip _____
Name of insurance _____
Mailing address _____
City _____ State _____ Zip _____
Policy # _____ Group ID # _____
(If A & B are both no, use condition code 9)

C. Disability − Is patient under the age of 65 ? ☐ Yes ☐ No
If yes, is the patient entitled to Medicare due to disability other than End Stage Renal Disease ? ☐ Yes ☐ No
If yes, is the patient receiving benefits from a health plan of more than 100 employees ? ☐ Yes ☐ No **(11)**
If yes, name of employer _____
Mailing address _____
City _____ State _____ Zip _____
Name of insurance _____
Mailing address _____
City _____ State _____ Zip _____
Name of policy holder _____ Relation to patient _____
Policy # _____ Group ID # _____

2. **Worker's Compensation** − Should the illness/injury be covered by a Worker's Compensation claim ? ☐ Yes ☐ No
(If yes, Cond. code 2, occur code 4)
If yes, original date of illness/injury _____ Claim # _____
Name of Worker's Compensation Plan _____
Mailing address _____
City _____ State _____ Zip _____
Name of employer _____
Mailing address _____
City _____ State _____ Zip _____

(Other)

3. Federal Black Lung − Is patient covered by Black Lung ? ☐ Yes ☐ No
Date benefits began _____
If yes, are you able to determine at this time if the claim will be covered by the Department of Labor ? ☐ Yes ☐ No

4. Department of Veterans Affairs − Is patient entitled to benefits through DVA ? ☐ Yes ☐ No
If yes, does the patient want DVA contacted for authorization of these services ? ☐ Yes ☐ No **(If no, Cond. code 26)**

5. Public Health Services − Are these services covered by a PHS other than Medicare or Medicaid ? ☐ Yes ☐ No
If yes, name of Public Health Service _____
Mailing address _____
City _____ State _____ Zip _____

6. Accident − Are these services the result of an accident ? ☐ Yes ☐ No
(If yes, occur code: 01 Auto, 02 No fault, 03 Tort liability, 05 Other, 06 Crime)
If yes, description of accident _____
_____
Date of accident _____ Location of accident _____
_____

A. Non−Liability Insurance − accident for which there is not a legal responsibility.
If yes, is there non − liability insurance available (premises medical, auto medical, no − fault auto, homeowners premises)
☐ Yes ☐ No**(If yes, occur code 02)**
If yes, name of insurance _____
Mailing address _____
City _____ State _____ Zip _____
Insured name _____

B. Liability Insurance − Does the patient feel someone else is responsible for the accident/injury ? ☐ Yes ☐ No
(If yes, occur code: 03 accident/tort, 05 other)
If yes, patient's attorney or responsible party's insurance _____
Mailing address _____
City _____ State _____ Zip _____
Name of insured on responsible party's insurance _____

7. End Stage Renal Disease
Are you an End Stage Renal Disease patient (receiving a routine course of dialysis) ☐ Yes ☐ No
Month/Yr of first regular dialysis_____
If yes, are you within the first 30 month coordination of benefits period ? ☐ Yes ☐ No **(If yes, Cond. code 06)**
If yes, is patient covered by a EGHP through a current of former employer of any size ? ☐ Yes ☐ No **(11)**
If yes, name of group health plan _____
Mailing address_____
City _____ State _____ Zip _____
Name of insured _____ Relationship to patient _____
Policy #_____ Group ID # _____
Name of employer _____
Mailing address _____
City _____ State _____ Zip _____
Has the patient had a kidney transplant ? ☐ Yes ☐ No If yes, date of transplant _____
Has the patient participated in a self−dialysis training program ? ☐ Yes ☐ No If yes, date training started _____

8. Dual Entitlement
Is the patient entitled to Medicare on the basis of either ESRD and AGE or ESRD and Disability ? ☐ Yes ☐ No
Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD ? ☐ Yes ☐ No
Does the working aged or MSP disability provision apply (i.e.: is the GHP primary based on the age or the disability entitlement) ? ☐ Yes ☐ No

NOTE: IF YES TO THE LAST QUESTION, THE GHP REMAINS PRIMARY FOR THE 30 MONTH COB PERIOD.

(Other)