**Medicare Secondary Payer Screening Questionnaire**

Patients Name Medicare #

1. Are you covered by the Veterans Administration,

the Black Lung Program, or Workers YES NO

Compensation? If so, circle which one.

1. Is this illness or injury due to any type of accident? YES NO
2. Are you age 65 or older? YES NO
3. Are you currently employed? YES NO
4. Have you ever been employed? YES NO
5. Is your spouse currently employed? YES NO
6. Are you 65 or under? YES NO

1. Are you covered by any employer Group Health

Plan or any other large Group Health Plan? YES NO

1. Do you have End Stage Renal Disease? YES NO
2. Have you received a kidney transplant? YES NO
3. Have you received maintenance dialysis

treatments? YES NO

1. If you participated in a self-dialysis

training program, provide date training started

1. Why do you receive Medicare? Circle one: AGE, DISABILITY, or ESRD

I declare, under penalty of perjury, that I do not have another primary insurance carrier to pay for medical care rendered to me by FHC of Camden, all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of authorized Medicare Benefits be made to this health center for any services furnished to me by its physicians and suppliers.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare Center as full charge, and the patient is responsible only for the deductible (Excluding UGS/Medicare) coinsurance and non-covered services. Coinsurance and deductible are based upon charge determined by the Medicare carrier.

Signature of Patient or Authorized Representative Date