Patient name:

Place label here

USC AMBULATORY SURGICAL CENTER
MEDICARE PATIENT INSURANCE QUESTIONNAIRE

Medicare regulations require we ask the following questions of all Medicare beneficiaries at the time of admission.

Part I

1. Are you receiving Black Lung (BL) Benefits?

   ____ YES **Date benefits began: _____ /_____ /_____** _____ NO

   Black Lung is primary only for claims related to black lung.

2. Are the services to be paid by a government program such as a research grant?

   ____ YES ____ NO **Name of program** _____

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

   ____ YES ____ NO
   If yes, DVA is primary.

4. Was the illness/injury due to a work related accident/condition?

   ____ YES **Date of injury/illness: _____ /_____ /_____** ____ NO **Go to Part II**

   If yes, name and address of Worker's Compensation Plan:

   _____

   _____

   Policy or identification number: _____

   Name and address of your employer:

   _____

   _____

   Workcomp is primary payer only for claims related to work related injuries or illness.

Part II

5. Was illness/injury due to a non-work related accident?

   ____ YES **Date of accident: _____ /_____ /_____** ____ NO **Go to Part III**

6. What type of accident caused the illness/injury?

   ____ Automobile ____ Non-automobile ____ Other

   Name and address of no-fault or liability insurer:

   _____

   _____
   No-fault insurer is primary payer only for those claims related to the accident.

7. Was another party responsible for this accident?

   ____ YES ____ NO

   Name and address of any liability insurer:

   _____

   _____

   _____

Part III

8. Are you entitled to Medicare based on:
   ____ Age
   ____ Disability
   ____ ESRD (End Stage Renal Disease)

9. Are you currently employed?

   ____ YES ____ NO *date of retirement* ____ /____ /____ ____ No *never employed*

10. Is your spouse currently employed?

    ____ YES ____ NO *date of retirement* ____ /____ /____ ____ No *never employed*
    If the patient answered no to both questions 9 and 10, Medicare is primary. Do not proceed further.

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

    ____YES ____ NO **Stop! Medicare is primary.**

12. Does the employer that sponsors your GHP employ 20 or more employees?

    ____ YES **Stop! Group Health Plan is primary. Obtain the following information.**

    ____ NO **Stop! Medicare is primary.**

    Name and address of GHP:

    _____

    _____

    _____

    Policy ID #: _____

    Group #: _____

    Name of policyholder: _____

    Relationship to patient: _____

13. Have you received a kidney transplant?

    ____ YES **Date of transplant:** ____ /____ /____ ____ NO

14. Have you received maintenance dialysis treatments?

    ____ YES **Date dialysis began:** ____ /____ /____ ____ NO

15. Are you within the 30 month (2 1/2 years) coordination period?

    ____ YES ____ NO **Stop! Medicare is primary.**

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

    ____ YES ____ NO **Stop! GHP is primary during the 30 month coordination period.**

17. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

    ____ YES ____ NO

18. Does the working age or disability MSP provision apply (i.e. is the GHP primarily based on age or disability entitlement)?

    ____ YES **Stop! GHP continues to pay primary during 30 month coordination period.**

    ____ NO **Medicare pays primary.**

I verify, to the best of my knowledge, the above statements are true.

Signature _____ Date _____
Patient/Representative