ARIZONA COMMUNITY SPECIALISTS

Medicare Secondary Payor Questionnaire (MSPQ)

Patient Name:_____

Date:_____ ACS Location:_____

THIS FORM IS REQUIRED BY MEDICARE. If you have Medicare or a Medicare replacement plan, circle the answer to the following questions:

Part I

1. Are you receiving Black Lung (BL) benefits? Yes No
   a. If Yes, dated benefits began:_____
2. Are these services related to Black Lung (is the diagnosis on the Dept of labor list?) Yes No
3. Are the services to be paid by a government research program/project? Yes No
   a. Has the DVA authorized and agreed to pay for the care at this facility? Yes No
4. Are you entitled to benefits through the Department of Veterans Affair (DVA)? Yes No
5. Was the illness/injury due to a work-related accident/condition? Yes No

Part II

1. Was the illness/injury due to a non-work-related accident? Yes No
   a. If yes, date of accident:_____
2. Is no-fault insurance available? Yes No
3. Is additional no-fault insurance available? Yes No
4. Is liability insurance available? Yes No
5. Is additional liability insurance available? Yes No
   a. Provide name and address of no-fault and/or liability insurer(s) and responsible party; insurance claim number(s):_____

Part III

1. Are you entitled to Medicare based on Age? Yes No
   (If Yes, Complete Part IV)
2. Are you entitled to Medicare based on Disability? Yes No
   (If Yes, Complete Part V)
3. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? Yes No
   (If Yes, Complete Part VI)

Part IV – Age:

1. Are you currently employed? Yes No
   a. If applicable, date of retirement: Date:_____
   b. Current employer name and address:_____
2. Do you have a spouse who is currently employed? Yes No
   a. If applicable, date of spouse retirement: Date:_____

b. Spouse employer name and address:_____

3. Do you have a group health plan (GHP) coverage based on your own current employment? Yes No
4. Do you have a group health plan (GHP) coverage based on your spouse's current employment? Yes No
5. If you have GHP coverage based on you own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees? Yes No
6. 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
   a. If covered by a GHP, list name, address and policy information:_____

Part V – Disability:

1. Are currently employed? Yes No
   a. If applicable, date of retirement: Date:_____
   b. Current employer name and address:_____
2. Do you have a spouse who is currently employed? Yes No
   a. If applicable, date of retirement: Date:_____
   b. Spouse's current employer name and address:_____
3. Do you have a group health plan (GHP) coverage based on your own current employment? Yes No
4. Do you have a group health plan (GHP) coverage based on your spouse's current employment? Yes No
5. Are you covered under a GHP based on the employment of a family member other than a spouse? Yes No
6. 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
7. 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
8. If you have GHP coverage based on family member's current employment, does your family member's employer that sponsors or contributes to the GHP employ 100 or more employees? Yes No
   a. If covered by a GHP, provide name, address, and policy information:_____

Part VI: End Stage Renal Disease (ESRD)

1. Do you have GHP coverage based on your own current or former employment? Yes No
2. Do you have GHP coverage through your spouse? Yes No
3. Do you have GHP coverage through a family member other than your spouse? Yes No
4. Have you received a kidney transplant? Yes No
5. Have you received maintenance dialysis treatment? Yes No
   a. Have you participated in self-dialysis training program? Yes No
6. Are you within the 30-month coordination period? Yes No
7. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? Yes No
8. Was your initial entitlement to Medicare (including simultaneously or dual entitlement, based on ESRD? Yes No
9. Does the working aged disability MSP provision apply (i.e. is the GHP already primary based on age or disability entitlement)? Yes No
   a. If covered by a GHP, provide name, address, and policy information:_____