



Frank Feigenbaum, M.D., FAANS, FACS

MEDICARE SECONDARY PAYER QUESTIONNAIRE

(To be completed for all Medicare patients)

NAME \_\_\_\_\_

DOB \_\_\_\_\_

(If any answer to questions 1a through 4 is yes, the corresponding section of "Other Insurance" form must be filled out completely)

- |  | YES | NO  |
|--|-----|-----|
| 1. Is the patient a Veteran?                                 | ___ | ___ |
| a. Did the VA refer you here for treatment?                  | ___ | ___ |
| b. Does the patient have a VA "fee basis ID card"?           | ___ | ___ |
| 2. Do you have a Federal Black Lung Card?                    | ___ | ___ |
| 3. Is this medical condition due to an accident of any kind? | ___ | ___ |
| If yes, was it: Work Related ___ Auto ___                    |     |     |
| Injured in own home ___ Other ___                            |     |     |

Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (NOT retiree coverage) \_\_\_ \_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

*Revised February 2018*