

NAME:

MSP QUESTIONNAIRE

DATE:

Part I:

1. Are you receiving Black Lung (BL) Benefits? YES / NO

If yes; BL is primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant? YES / NO

If yes; Government Program will pay primary benefits for these services.

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 for these services.

4. Was the illness/injury due to a work-related accident/condition? YES / NO

If yes; Date of injury/illness: ____/____/____

Name and address of WC plan:

Name and address of Employer:

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

Go to Part III.

If no; Go to Part II.

Part II:

1. Was illness/injury due to a non-work related **accident**? YES / NO

If yes; Date of accident: ____/____/____

If no; Go to Part III.

2. What type of accident caused the illness/injury? AUTO NON-AUTO OTHER

Name and address of no-fault or liability insurer:

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

Go to Part III.

Part III:

1. Are you entitled to Medicare based on:

____ Age. **Go to Part IV.**

____ Disability. **Go to Part V. Ask Receptionist.**

____ ESRD. **Go to Part VI. Ask Receptionist.**

Part IV:

1. Are you or your spouse currently employed? YES / NO

If yes; Name and address of employer:

Ask Receptionist.

If no; Medicare is primary. STOP

Continue Part IV:

2. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? YES / NO

If no; STOP. Medicare is primary.

3. Does the employer that sponsors your GHP employ 20 or more employees? YES / NO

If yes; STOP. Group Health Plan is primary.

If no; STOP. Medicare is primary.

Part V:

1. Are you currently or a family member currently employed? YES / NO

If yes; Name and address of your employer:

If no; STOP. Medicare is primary.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment? YES / NO

If no; STOP. Medicare is primary.

4. Does the employer that sponsors your GHP, employ 100 or more employees? YES / NO

If yes, STOP. Group Health Plan is primary.

Part VI:

1. Do you have group health plan (GHP) coverage? YES / NO

If no; STOP. Medicare is primary.

2. Have you received a kidney transplant? YES / NO

If yes; Date of transplant: ____/____/____

3. Have you received maintenance dialysis treatments? YES / NO

If yes; Date dialysis began: ____/____/____

If you participated in a self dialysis training program, provide

Date training started: ____/____/____

4. Are you within the 30 month coordination period? YES / NO

If no; STOP. Medicare is primary.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? YES / NO

If no; STOP. GHP is primary during the 30 month coordination period.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? YES / NO

If yes; STOP. GHP continues to pay primary during the 30 month coordination period.

If no; Initial entitlement based on age or disability.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)? YES / NO

If yes; GHP continues to pay primary during the 30 month coordination period.

If no; Medicare continues to pay primary.