

To be completed only by patients with Medicare

MSP Questionnaire

Thank you for your completion of these questions. Medicare regulations require that we verify this information at each visit. At subsequent visits, we will ask about changes to the information to keep our information current.

1. You are entitled to Medicare based on: (Please check one)

Age Disability End-Stage Renal Disease (ESRD)

Please note that both Age and ESRD OR Disability and ESRD may be selected simultaneously. Age and disability may not be checked simultaneously.

2. Are you receiving Black Lung Benefits? Yes No

If yes, date benefits began _____
(Month/Date/Year)

3. Are the services to be paid by a government research program? Yes No

4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility? Yes No

5. Was the illness or injury due to a work-related accident or condition?

Yes No

6. If you are seeking treatment for an injury, was another party responsible for the injury? Yes No

7. Are you currently employed? Yes No No. Never employed.

Date of retirement, if applicable: _____
(Month/Date/Year)

8. Do you have a spouse who is currently employed?

Yes No No. Never employed.

Date of retirement, if applicable: _____
(Month/Date/Year)

9. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment? Yes, both Yes, self Yes, spouse No

10. Do you carry any other insurance? Yes No

If yes, please list company name, address, agent, and policy number:

1. _____

2. _____

Policy Number: _____

Policy Number: _____

Name: _____

Date of Birth: _____

PLEASE PRINT

Signature: _____

Date: _____