Vance Family Medicine Medicare Secondary Payer (MSP) Form

Patient Name: _____
Medicare #: _____
Date: _____ / _____ / _____

Check (✔) the appropriate items:

1. **Do you receive Veteran's benefits?** ☐ Yes ☐ No

2. **Are you receiving benefits under the Black Lung Program?** ☐ Yes ☐ No

3. **Was this injury / illness due to a work related accident/condition?** ☐ Yes ☐ No

4. **Was this injury / illness related to an automobile accident?** ☐ Yes ☐ No

5. **Was this injury / illness related to an accident in which you intend to file a liability suit or litigation is pending?** ☐ Yes ☐ No
   If "Yes," please provide: Attorney's name: _____
   Address: _____
   Phone Number: _____

6. **Are you entitled to Medicare based on:** ☐ Age (65 & Over) **(Go to Question #7)**
   ☐ Disability **(Go to Question #7)**
   ☐ End Stage Renal Disease
   Do you have group health plan coverage? ☐ Yes ☐ No

7. **Are you currently employed?** ☐ Yes ☐ No
   Date of Retirement: _____ / _____ / _____
   a) **Is your spouse currently employed?** ☐ Yes ☐ No
      Date of Retirement: _____ / _____ / _____
   b) **Do you have a group health plan as primary coverage based on your own or spouse's current (or former) employment?** ☐ Yes ☐ No
   c) **Does the employer that sponsors your group health plan employ 20 or more employees?** ☐ Yes ☐ No

If you answered "Yes" to Questions #3, #4, or #7 above, please complete the following information:

Insurance Co.: _____
Address: _____
Policy #: _____
Group Name: _____