Harbor Light HOSPICE

MEDICARE SECONDARY PAYOR WORKSHEET

PATIENT NAME: _____ **MR#:** _____

MEDICARE #: _____ **EFFECTIVE DATE:** _____

PART I

1.	Is the patient age 65 or over?	☐ Yes ☐ No
2.	Is the patient under 65 and a disabled Medicare beneficiary?	☐ Yes ☐ No
3.	Is the patient employed and covered by an employer's HMO or large group-health plan?**	☐ Yes ☐ No
4.	Is the patient's spouse employed and covered by a large group health plan?**	☐ Yes ☐ No
5.	Is the patient receiving benefits from the health plan of an employer for whom he/she used to work?**	☐ Yes ☐ No
	Is the patient covered under this policy?	☐ Yes ☐ No
	Is it a Medicare supplemental policy?**	☐ Yes ☐ No
6.	Is the patient receiving benefits from another family member other than the spouse?**	☐ Yes ☐ No
7.	Is the patient retired?	☐ Yes ☐ No
	Date of retirement: _____/_____/_____	
8.	Is the patient's spouse retired?	☐ Yes ☐ No
	Date of retirement: _____/_____/_____	
9.	Was illness/injury due to a work related accident/condition? **	☐ Yes ☐ No
10.	Is this illness/injury covered by Federal Black Lung Compensation? **	☐ Yes ☐ No
11.	Is this illness/injury due to a non-work related accident? **	☐ Yes ☐ No
12.	Are you receiving Veteran's benefits for this illness/injury?	☐ Yes ☐ No
13.	Are you entitled to Medicare solely as a result of End Stage Renal Disease?	☐ Yes ☐ No
	If yes, date entitlement began: _____/_____/_____	

**** If answer is Yes, please complete Part II.**

PART II

If the answer to questions 3, 4, 5 or 6 is Yes, please complete the following:

Name of Insurance Company: _____

Address: _____

City/State/ZIP: _____ Telephone: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____ Relationship: _____

If the answer to questions 9,10 or 11 is yes, please complete the following:

Date of Accident/Date Illness Began: _____/_____/_____ Claim #: _____

Insurance Company/Insurer: _____

Responsible Party (non-work related accident): _____

Employer: _____

Address: _____

City/State/ZIP: _____ Telephone: _____

Hospice Representative Signature: _____ Date: _____