anatomiimaging
a Via Christi Health Partner

316.462.2000
Wichita, KS
www.anatomiimaging.com

Medicare Secondary Payer Questionnaire

To be completed for all Medicare patients

Last Name _____ First Name _____ M.I. ____

Appointment Date _____ Location _____

YYYY-MM-DD

PART I

Are you receiving Black Lung (BL) Benefits? ..... ◯Yes ◯No

- *If yes, you can **STOP NOW**. BL will pay primary benefits for these services.*

  Please provide date benefits began: _____

Are the services to be paid by a government program such as a research grant? ..... ◯Yes ◯No

- *If yes, you can **STOP NOW**. The government program will pay primary benefits for these services.*

Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? ..... ◯Yes ◯No

- *If yes, you can **STOP NOW**. DVA will pay primary benefits for these services.*

Was the illness or injury due to a work-related accident or condition? ..... ◯Yes ◯No

- *If yes, you will need to fill out **Part III** at your appointment check-in. This form is not available online.*

Was the illness or injury due to a non-work related accident? ..... ◯Yes ◯No

- *If yes, you will need to fill out **Part IV** at your appointment check-in. This form is not available online.*

Are you entitled to Medicare based on:

◯ Age - *Please continue to **Part II**.*

◯ Disability - *You will need to fill out **Part V** at your appointment check-in. This form is not available online.*

◯ ESRD - *You will need to fill out **Part IV** at your appointment check-in. This form is not available online.*

Are you receiving any of the following?

Skilled Nursing Services..... ◯ Yes ◯ No

Hospice Care..... ◯ Yes ◯ No

Home Health Service..... ◯ Yes ◯ No

- *If you answered Yes to any of the above, we will require the following information about your service provider:*

  Name: _____

  Address: _____

  Phone: _____

If you do not need to proceed to Part II, you can submit your form now.

Print

Save

Submit

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3636 N. Ridge Road
Wichita KS 67205

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PART II - AGE

Are you currently employed? ..... ◯Yes ◯No

- *If yes, please provide the following information about your employer:*

  Name: _____

  Address: _____

- *If you are retired, please provide date of retirement:* _____

Is your spouse currently employed? ..... ◯Yes ◯No

- *If yes, please provide the following information about your spouse's employer:*

  Name: _____

  Address: _____

- *If your spouse is retired, please provide date of retirement:* _____

If you answered No to both of the above questions, do not proceed any further.
Medicare is the primary, unless you answered Yes to questions in Part I.

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

- *If no, do not proceed further. Medicare is the primary, unless you answered Yes to questions in Part I.*

Does the employer that sponsors your GHP employ 20 or more people? ..... ◯Yes ◯No

- *If yes, do not proceed further. Group Health Plan is primary.*
  Please obtain the following information about your GHP:

  Name: _____

  Address: _____

- *If no, do not proceed further. Medicare is the primary, unless you answered Yes to questions in Part I.*

Print
Save
Submit