

# Hess Clinic

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## MEDICARE SECONDARY PAYER QUESTIONNAIRE (TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

NAME: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_

(If any answer to questions 1a. through 4. is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

- |  | YES   | NO    |
|--|-------|-------|
| 1. Is the patient a Veteran?   | _____ | _____ |
| a. Did the VA refer you here for treatment?  | _____ | _____ |
| b. Does the patient have a VA "fee basis ID Card?"   | _____ | _____ |
| 2. Do you have a Federal Black Lung Card?  | _____ | _____ |
| 3. Is this medical condition due to an accident of any kind?   | _____ | _____ |
| If yes was it: <input type="checkbox"/> Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Injured in own home <input type="checkbox"/> Other |       |       |
| 4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage)               | _____ | _____ |