

# Gastroenterology Associates

Gastroenterology and Hepatology

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## MEDICARE SECONDARY PAYER FORM

As a direct result of mandated Medicare regulations, we are required to gather the following information to determine if Medicare is your primary insurance. If you answer "Yes" to any of these Questions, please bring them to the attention of the front desk.

### GENERAL ELIGIBILITY

- Are you currently in a nursing facility?  No  Yes  
If so, which one? \_\_\_\_\_
- Is this visit covered by the Veterans Administration?  No  Yes
- Is this visit the result of an injury due to an accident?  No  Yes

### EMPLOYMENT INFORMATION

- Are you currently employed?  No  Yes  
If not, what is your retirement date, if applicable? \_\_\_\_\_  
If so, does your employer have an employer group health plan?  No  Yes  
If so, are there over 20 employees?  No  Yes
- Is your spouse currently employed?  No  Yes  NA  
If not, what is the retirement date, if applicable? \_\_\_\_\_  
If so, does your employer have an employer group health plan?  No  Yes  
If so, are there over 20 employees?  No  Yes

### OTHER QUALIFYING PROGRAMS

- Are you currently receiving Black Lung Benefits?  No  Yes
- Are these services to be paid by government research program?  No  Yes
- Are you eligible for Medicare due to End Stage Renal Disease?  No  Yes  
If so, do you have a group health plan? (Does *not* mean Kaiser)  No  Yes  
If so, have you received a kidney transplant?  No  Yes  
Have you received maintenance dialysis treatments?  No  Yes  
If so, date dialysis began \_\_\_\_\_  
Are you within the 30 month coordination period that starts the first month an individual is eligible for Medicare because of kidney failure?  No  Yes

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Signature of Patient

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Date