



# Medicare Secondary Payor Development Form

Patient's Name _____	Account No. _____	Medicare No. _____
12. Does the employer that sponsors your GHP employ 20 or more employees? <input type="checkbox"/> No; <b>Stop. Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.</b> <input type="checkbox"/> Yes; <b>Stop. Group Health Plan is Primary. Obtain the following information.</b> Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	17. Do you have group health plan (GHP) coverage? <input type="checkbox"/> No: <i>Stop. Medicare is Primary.</i> <input type="checkbox"/> Yes; Provide name, address and phone of GHP: _____ _____ Policy ID Number _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____ Name, address and phone of employer, if any from which you received GHP coverage: _____ _____	
13. Are you currently employed? <input type="checkbox"/> No; Date of Retirement _____ <input type="checkbox"/> Yes; Provide name, address and phone of your employer: _____ _____	18. Have you received a kidney transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date of Transplant: _____	
14. Is a family member currently employed? <input type="checkbox"/> No <input type="checkbox"/> Yes; Provide name, address and phone of employer: _____ _____ <i>If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. Do not proceed any further.</i> <i>If Yes to questions 13 or 14, go to question 15 and 16.</i>	19. Have you received maintenance dialysis treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date dialysis began: _____ If you participated in self dialysis training program, provide date training started: _____	
15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment? <input type="checkbox"/> No; <b>Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.</b> <input type="checkbox"/> Yes	20. Are you within the 30 month coordination period? <input type="checkbox"/> No; <b>Stop. Medicare is Primary.</b> <input type="checkbox"/> Yes	
16. Does the employer that sponsors your GHP, employ 100 or more employees? <input type="checkbox"/> No; <b>Stop. Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.</b> <input type="checkbox"/> Yes; <b>Stop. Group Health Plan is Primary. Obtain the following information:</b> Name, address and phone of GHP: _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of Policy Holder _____ Relationship to Patient _____	21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability? <input type="checkbox"/> No; <b>Stop. GHP is Primary during the 30 month coordination period</b> <input type="checkbox"/> Yes	
17. (Continued from previous page)	22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD? <input type="checkbox"/> No; <i>Initial entitlement based on age or disability.</i> <input type="checkbox"/> Yes; <b>Stop. GHP continues to pay Primary during the 30<sup>th</sup> month coordination period.</b>	
I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.		
X _____ Patient or Representative / Relationship	X _____ Witness	_____ Date