

**Clinical Telehealth Program**

**MEDICARE SECONDARY PAYER QUESTIONNAIRE (MSPQ)**

**Page 1**

# *Improving Lives and Transforming Health Care*

|  |  |  |  |
| --- | --- | --- | --- |
| PART I | | | |
| 1. Are you receiving Black Lung (BL) Benefits? | | |  |
| Date benefits began: | | |  |
| Are these services related to Black Lung (is the diagnosis on the Department of Labor list)? | | |  |
| 1. Are the services to be paid by a government research program? | | |  |
| 1. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? | | |  |
| Has the DVA authorized and agreed to pay for your care at this facility? | | |  |
| 1. Was the illness/injury due to a work-related accident/condition? | | | If no, go to Part II |
| Date of injury/illness: |  | Policy or identification number: |  |
| Workers' compensation plan name: |  | Employer name: |  |
| Plan address: |  | Employer address: |  |
| City: |  | City: |  |
| State: | ZIP: | State: | ZIP: |

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| PART II | | | | | |
| 1. Was the illness/injury due to a non-work-related accident? | | | | | If no, go to Part III |
| Date of accident |  | |  | | |
| 1. Is no-fault insurance available? \* |  | |
| No-fault insurance plan name: |  | | No-fault policy owner name: |  | |
| Plan address: |  | | Policy owner address: |  | |
| State: | ZIP: | | State: | | ZIP: |
| >>> NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT | | | | | |
| Is additional no-fault insurance available? | |  | | | |
| Name and address of additional no-fault insurer(s) and no-fault insurance policy owner, insurance and claim number(s): | | | | | |
|  | | | | | |
| \*No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident. | | | | | |
| 1. Is liability insurance available? \*\* |  | | | | |
| Liability insurance plan name: |  | | Responsible party name: | |  |
| Plan address: |  | | Responsible party address: | |  |
| State: | ZIP: | | State: | | ZIP: |
| >>> LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD. | | | | | |
| Is additional liability insurance available? | |  | | | |
| Name and address of additional liability insurer(s) and responsible party, insurance and claim number(s): | | | | | |
|  | | | | | |
| \*\* No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident. | | | | | |



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| PART III | |
| 1. Are you entitled to Medicare based on Age? | If “Yes,” complete PART IV |
| 1. Are you entitled to Medicare based on Disability? | If “Yes,” complete PART V |
| 1. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? | If “Yes,” complete PART VI |
| * Please note that both “Age” and “ESRD” OR both “Disability and “ESRD” may be selected simultaneously. * An individual cannot be entitled to Medicare based on “Age” and “Disability” simultaneously. * Please complete ALL “PARTS” associated with the patient’s selections. * If the patient is entitled to Medicare, he/she should answer “Yes” to at least one of the three entitlement questions above. | |

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| PART IV – AGE | | | | | |
| 1. Are you currently employed? |  | | | If applicable, date of retirement: |  |
| Employer name: |  | | | City: |  |
| Employer address: |  | | | State: | ZIP: |
| 1. Do you have a spouse who is currently employed? | |  | | If applicable, date of retirement: |  |
| Employer name: |  | | | City: |  |
| Employer address: |  | | | State: | ZIP: |
| 3a. Do you have a group health plan (GHP) coverage based on your own current employment? | | | | |  |
| 3b. Do you have a group health plan (GHP) coverage based on your spouse’s current employment? | | | | |  |
| 1. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees? | | | | |  |
| GHP name: |  | | Policy Identification number: \* | |  |
| GHP address: |  | | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | | Name of policyholder/named insured: | |  |
| State: | ZIP: | | Relationship to patient: | |  |
| 1. If you have GHP coverage based on your spouse’s current employment, does your spouse’s employer that sponsors or contributes to the GHP employ 20 or more employees? | | | | |  |
| GHP name: |  | | Policy Identification number: \* | |  |
| GHP address: |  | | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | | Name of policyholder/named insured: | |  |
| State: | ZIP: | | Relationship to patient: | |  |
| \* The policy indentification number is sometimes referred to as the health insurance benefit package number.  \*\* Prior to HIPAA, the membership number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient. | | | | | |



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| PART V – DISABILITY | | | | | |
| 1. Are you currently employed? |  | | | If applicable, date of retirement: |  |
| Employer name: |  | | | City: |  |
| Employer address: |  | | | State: | ZIP: |
| 1. Do you have a spouse who is currently employed? | |  | | If applicable, date of retirement: |  |
| Employer name: |  | | | City: |  |
| Employer address: |  | | | State: | ZIP: |
| 3a. Do you have a group health plan (GHP) coverage based on your own current employment? | | | | |  |
| 3b. Do you have a group health plan (GHP) coverage based on your spouse’s current employment? | | | | |  |
| 1. Are you covered under a GHP based on the current employment of a family member other than your spouse? | | | | |  |
| Employer name: |  | | | City: |  |
| Employer address: |  | | | State: | ZIP: |
| 1. If you have GHP coverage based on your current employment, does your employer that sponsors or contributes to the GHP, employ 100 or more employees? | | | | |  |
| GHP name: |  | | Policy Identification number: \* | |  |
| GHP address: |  | | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | | Name of policyholder/named insured: | |  |
| State: | ZIP: | | Relationship to patient: | |  |
| 1. If you have GHP coverage based on your spouse’s current employment, does your spouse’s employer that sponsors or contributes to the GHP, employ 100 or more employees? | | | | |  |
| GHP name: |  | | Policy Identification number: \* | |  |
| GHP address: |  | | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | | Name of policyholder/named insured: | |  |
| State: | ZIP: | | Relationship to patient: | |  |
| 1. If you have GHP coverage based on a family member’s current employment, does your family member’s employer that sponsors or contributes to the GHP, employ 100 or more employees? | | | | |  |
| GHP name: |  | | Policy Identification number: \* | |  |
| GHP address: |  | | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | | Name of policyholder/named insured: | |  |
| State: | ZIP: | | Relationship to patient: | |  |
| \* The policy indentification number is sometimes referred to as the health insurance benefit package number.  \*\* Prior to HIPAA, the membership number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient. | | | | | |



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| PART VI – ESRD | | | | |
| 1a. Do you have GHP coverage based on your own current or former employment? | | | |  |
| Your GHP information: | | | | |
| GHP name: |  | Policy Identification number: \* | |  |
| GHP address: |  | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | Name of policyholder/named insured: | |  |
| State: | ZIP: | Relationship to patient: | |  |
| Employer from which you receive GHP coverage: | | | | |
| Employer name: |  | |  | |
| Employer address: |  | |
| City: |  | |
| State: | ZIP: | |
| 1b. Do you have GHP coverage based on your spouse? | | | |  |
| Your spouse’s GHP information: | | | | |
| GHP name: |  | Policy Identification number: \* | |  |
| GHP address: |  | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | Name of policyholder/named insured: | |  |
| State: | ZIP: | Relationship to patient: | |  |
| Employer from which your spouse receives GHP coverage: | | | | |
| Employer name: |  | |  | |
| Employer address: |  | |
| City: |  | |
| State: | ZIP: | |
| 1c. Do you have GHP coverage through a family member other than your spouse? | | | |  |
| Your family member’s GHP information: | | | | |
| GHP name: |  | Policy Identification number: \* | |  |
| GHP address: |  | Group identification number: | |  |
| Membership number: \*\* | |  |
| City: |  | Name of policyholder/named insured: | |  |
| State: | ZIP: | Relationship to patient: | |  |
| Employer from which your family member receives GHP coverage: | | | | |
| Employer name: |  | |  | |
| Employer address: |  | |
| City: |  | |
| State: | ZIP: | |
| \* The policy indentification number is sometimes referred to as the health insurance benefit package number.  \*\* Prior to HIPAA, the membership number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient. | | | | |



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| PART VI – ESRD (CONTINUED) | | | |
| 1. Have you received a kidney transplant? |  | Date of transplant: |  |
| 1. Have you received maintenance dialysis treatments? |  | Date dialysis began:: |  |
| Have you participated in a self-dialysis training program? |  | Date training started: |  |
| 1. Are you within the 30-month coordination period? \* | | |  |
| 1. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? \*\* | | |  |
| 1. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD? | | |  |
| 1. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)? \*\*\* | | |  |
| \* The 30-month coordination period starts the first da of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure.  \*\* This question is answered automatically based on the responses to questions 1 and 2 in PART III.  \*\*\* This question is answered Yes automatically if the patient answered Yes to question(s) 4 and/or 5 in PART IV (which indicates the working aged provision applies) or questions(s) 5, 6, and/or 7 in PART V (which indicates the disability provision applies). | | | |