Conroe Surgery Center

Medicare Secondary Payer Questionnaire

(short form) (please use long form if any questions are answered YES)

1. Are you currently residing in a skilled nursing facility, nursing home, or any other long-term care facility? ___no ___ yes
2. Are you receiving hospice benefits? ___no ___yes
3. Are you receiving benefits from any of the following programs?
    a. Black Lung ___no ___yes
    b. Research Grant ___no ___yes
    c. Veteran Affairs ___no ___yes
4. Was the illness/injury due to a work related accident? ___no ___yes
5. Was the illness/injury due to a non-work related accident? ___no ___yes
6. Are you entitled to Medicare based on
    a. Age ___
    b. Disability ___
    c. ESRD ___
7. Are you currently employed? ___no ___yes
8. Is your spouse currently employed? ___no ___yes
9. Do you have Group Health Plan coverage? ___no ___yes
10. Does the employer who sponsors your Group Health Plan coverage employ 20 or more employees? ___no ___yes

I confirm that the above information is correct.

Patient Signature: _____

Date: _____