PRO IMPACT
PHYSICAL THERAPY • SPORTS PERFORMANCE

MEDICARE SECONDARY PAYER QUESTIONNAIRE

There may be situations where **MEDICARE IS NOT YOUR PRIMARY PAYER** or Medicare coverage policies vary. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.

Patient Name:_____

☐ YES ☐ NO 1. Are you currently receiving **any** Home Health Services?

☐ YES ☐ NO 2. Are you covered under a Medicare Part C (Medicare Advantage/Medicare+Choice program?

☐ YES ☐ NO 3. If you are entitled to Medicare based upon Age or Disability, are you currently employed?
If YES, provide your employer's information on the Patient Registration form.
If NO, enter your retirement date:_____ ☐ Never Employed

☐ YES ☐ NO 4. Do you have a spouse that is currently employed?
If YES, provide your spouse's employer's information on the Patient Registration Form.
If NO, enter your spouse's retirement date:_____ ☐ Never Employed

☐ YES ☐ NO 5. Do you have group health plan coverage based upon your own or your spouse's employment?
If YES, enter you and/or your spouse's group health plan information in Section II.

Type of Insurance Coverage: ☐ Workers Compensation ☐ No-fault Auto or Liability ☐ Group Health Plan

Insurance Name _____

Street Address _____

City, State, Zip _____

Phone Number _____

Policy Number _____

Group Number _____

Name of Policy Holder _____

I certify that all of the information provided herein in true and correct.

_____ _____

Signature of Patient/Representative **Date**