HOMEPSYCH

ADMISSION QUESTIONS TO ASK MEDICARE BENEFICIARIES

The following outline of questions provides points of data to gather from Medicare beneficiaries that are helpful for providers to determine who has primary payment responsibility for a claim or set of claims by asking the questions upon each inpatient and outpatient admission. The information assists in the proper coordination of benefits to ensure adherence to Medicare Secondary Payer (MSP) provision as outlined in section 1862(b) of the Social Security Act.

PART I. INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

1. Are you receiving benefits under the Black Lung Benefits Act (BL)?
   Yes; Date Black Lung Benefits began: ____ /____ /____
   No
   NOTE: BL IS THE PRIMARY FOR CLAIMS RELATED TO BL.

2. Was the illness/injury due to a work-related accident/condition?
   Yes; The following WC information is required to submit claims appropriately:
   No
   Name and address of employer:
   ____
   ____
   Name and address of employer:
   ____
   ____
   Policy or claim number: ______________________________
   Date of the workplace illness or the injury: ____ /____ /____
   NOTE: WC IS THE PRIMARY PAYER ONLY FOR SERVICES RELATED TO WORK-RELATED INJURIES OR ILLNESS.

3. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?
   Yes; The following no-fault/auto insurance information is required to submit claims appropriately:
   No
   Name and address of insurance carrier:
   ____
   ____
   Policy or claim number: ______________________________
   Date of illness or the injury: ____ /____ /____
   NOTE: NO-FAULT INSURANCE IS THE PRIMARY PER ONLY FOR SERVICES RELATED TO THE ACCIDENT.

4. Are you receiving treatment for an injury, or illness, which another party may be liable?
   Yes: The following liability information is required to submit claims appropriately:
   No
   Name and address of insurance carrier:
   ____
   ____
   Policy or claim number: ______________________________
   Date of illness or the injury: ____ /____ /____
   NOTE: LIABILITY INSURANCE IS THE PRIMARY PAYER ONLY FOR SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD.

PART II. INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

1. Are you entitled to Medicare based on Age, Disability or ESRD?
   Age.
   Disability.
   End-Stage Renal Disease (ESRD).
   NOTE: IF ENTITLEMENT IS BASED SOLELY ON ESRD, SKIP PART II AND COMPLETE PART III. STOP AFTER COMPLETING PART II IF YOU ARE ENTITLED TO MEDICARE BASED ON AGE OR DISABILITY.

2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member?
   Yes. **THE EMPLOYER GHP MAY BE PRIMARY TO MEDICARE. CONTINUE BELOW.**
   No. **STOP HERE AS MEDICARE IS PRIMARY.**

3. How many employees, including yourself or spouse, work for the employer from whom you have GHP coverage?
   1-19
   20-99
   100 or more
   NOTE: IF YOU ARE AGED AND THERE ARE 20 OR MORE EMPLOYEES, YOUR GHP IS PRMARY. IF YOU ARE DISABLED AND YOUR EMPLOYER, SPOUSE, OR FAMILY MEMBER EMPLOYER, HAS 100 OR MORE EMPLOYEES, YOUR GHP IS PRMARY.

   The following employer GHP information is required to submit claims appropriately:

   Name and address of the employer (your own or your spouse's/family member's) through which you receive GHP coverage. ______________________________
   ____
   ____

   Name and address of GHP: ______________________________
   ____
   ____

   Policy number (health insurance benefit package number): ______________________________
   Group Number: ______________________________
   Date the GHP coverage began: ____ /____ /____
   Name of policyholder (if coverage is through your spouse/other family member):________________
   Relationship to patient (if other than self):______________________________

PART III. INFORMATION ABOUT THE PATIENT IF ESRD MEDICARE ENTITLEMENT APPLIES (INCLUDING DUAL ENTITLEMENT: AGE AND ESRD OR DISABILITY AND ESRD)

1. Do you have employer group health plan (GHP) coverage through yourself, a spouse, or family member if dually entitled based on Disability and ESRD?
   Yes. **THE EMPLOYER GHP MAY BE PRIMARY TO MEDICARE. CONTINUE BELOW.**
   No.

2. Have you received a kidney transplant?
   Yes; Date of transplant: ____ /____ /____
   No.

3. Have you received maintenance dialysis treatments?
   Yes; Date dialysis began: ____ /____ /____
   No.

4. Are you within the 30-month coordination period?
   Yes.
   No.
   NOTE: THE 30-MONTH COORDINATION PERIOD STARTS THE FIRST DAY OF THE MONTH AN INDIVIDUAL IS ELIGIBLE FOR MEDICARE (EVEN IF NOT YET ENROLLED IN MEDCARE) BECAUSE OF KIDNEY FAILURE (USUALLY THE FOURTH MONTH OF DIALYSIS) REGARDLESS OF ENTITLEMENT DUE TO AGE OR DISABILITY. IF THE INDIVIDUAL IS PARTICIPATING IN A SELF-DIALYSIS TRAINING PROGRAM OR HAS A KIDNEY TRANSPLANT DURING THE 3-MONTH WAITING PERIOD, THE 30-MONTH COORDINATION PERIOD STARTS WITH THE FIRST DAY OF THE MONTH OF DIALYSIS OR KIDNEY TRANSPLANT.

5. Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRD (or simultaneous entitlement) due to ESRD and Age or ESRD and Disability)?
   Yes. **NOTE: THE GHP IS PRMARY DURING THE 30-MONTH COORDINATION PERIOD.**
   No.

   The following information is required to submit claims appropriately:

   Name and address of the employer (your own or your spouse's/family member's) through which you receive GHP coverage. ____________________
   ____
   ____

   Name and address of GHP: ____________________
   ____
   ____

   Policy number (health insurance benefit package number): ____________________
   Group number:____________________
   Name of policyholder (if coverage is through your spouse/other family member):____________________
   Relationship to patient (if other than self): ____________________

Print Patient/Beneficiary Name:____________________

Patient Signature:____________________ Date: ____________________