KAISER PERMANENTE® *HAWAII REGION*

Medicare Secondary Payor (MSP) Questionnaire (Non-Risk / Non-Cost)

DO NOT COMPLETE FOR KP MEDICARE (SR ADV/COST)

MR #: _____

Name: _____

Sex: ❑ Male ❑ Female **BD:** ____ | ____ | _____

Receptionist: _____ **Loc:** _____ **Guarantor Type:** PF ☐ WC ☐ NF ☐ Other: _____

Use BLACK ball point pen. **Birthdays require full year (example: 1907 instead of '07)*

1. ***Name of spouse:*** _____

2. ***Is the patient employed?*** *(If "Yes", answer 2a If "No", go to 3)* ---------- (circle) ☐Yes ☐No

   a. Employer Info: Name: _____
   Address: _____
   City: _____ State: _____ ZIP: _____ Phone: _____
   Number of employees (estimate): 1 - 19: ☐ 20 - 99: ☐ 100 or more: ☐

3. ***Is spouse employed?*** *(If "Yes", answer 3a If "No", go to 4)* ---------- ☐Yes ☐No

   a. Spouse
   Employer Info: Name: _____
   Relation to patient: _____
   Employer Name: _____
   Employer Address: _____
   City: _____ State: _____ ZIP: _____ Phone: _____
   Number of employees (estimate): 1 - 19: ☐ 20 - 99: ☐ 100 or more: ☐

4. ***Is the patient covered by an Employer Group Health Plan (EGHP) through a current or previous (pre-retirement) employer?*** *(EGHP = Health Insurance provided by an employer - not an individual plan)* ---------- ☐Yes ☐No

   a. Is the patient also covered by another (secondary) EGHP? ---------- ☐Yes ☐No

   b. Primary (EGHP)
   Employer Info: Insured (subscriber) name: _____
   Relation to patient: _____
   Patient's Primary Care Physician: _____
   Employer that sponsors the EGHP: _____
   Employer Address: _____
   City: _____ State: _____ ZIP: _____ Phone: _____

   c. Primary (EGHP) (List all health insurance coverages including Kaiser)
   Insurance Info: Payor • Plan name: _____
   Payor • Plan address: _____
   City: _____ State: _____ ZIP: _____ Phone: _____
   HMO: (circle) ☐Yes ☐No If "Yes": enter Medical Record # or ID#: _____
   Group: (Number/subgroup) _____

   d. Does the employer that provides the EGHPhave 20 or more employees? ---------- ☐Yes ☐No

5. ***Is Patient or spouse retired?*** *(If "Yes", answer 5a - 5b If "No" go to 6)* ---------- ☐Yes ☐No

   a. Patient retirement date: ____ | ____ | ____ (MM | DD | YY)

   b. Spouse retirement date: ____ | ____ | ____ (MM | DD | YY)

6. ***Is patient entitled to Medicare because of End Stage Renal Disease (ESRD)?*** *(If "Yes", answer 6a - 6e If "No" go to 7)* ---------- ☐Yes ☐No

   a. Date dialysis began: ____ | ____ | ____ (MM | DD | YY)

   b. In 30 month coordination period: ---------- ☐Yes ☐No

   c. Receiving training for self-dialysis: ---------- ☐Yes ☐No
   If Yes: Date self dialysis training started: ____ | ____ | ____ (MM | DD | YY)

   d. Initial entitlement to Medicare based on ESRD? ---------- ☐Yes ☐No
   If Yes: Date Part A effective: ____ | ____ | ____ (MM | DD | YY)

   e. Had transplant? ---------- ☐Yes ☐No
   If Yes: Date of transplant: ____ | ____ | ____ (MM | DD | YY)

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DO NOT COMPLETE FOR KP MEDICARE (SR ADV/COST)

Original: 09/23/05
Revised: 12/19/07

Date: MM | DD | YY*
Original: Military

MR #: _____

Name: _____

Sex: ☐ Male ☐ Female **BD:** ____ | ____ | _____

(Continued from front) **Birthdays require full year (example: 1907 instead of '07)*

circle

7. ***Is patient entitled to Medicare because of disability, other than ESRD?*** *(If "Yes", answer 7a If "No" go to 8)* ------ ☐ Yes ☐ No
   a. Does employer of the primary medical insurance (that sponsors patient's Group Health plan) have 100 or more employees? -------- ☐ Yes ☐ No
8. ***Is patient entitled to benefits through the Dept. of Veterans Affairs?*** *(If "Yes", answer 8a If "No" go to 9)* --------- ☐ Yes ☐ No
   a. Does the patient want the VAto be contacted for authorization? ---------- Yes ☐ No ☐
9. ***Is patient entitled to benefits under the Federal Black Lung Program?*** *(If "Yes", answer 9a - 9b If "No" go to 10)* ☐ Yes ☐ No
   a. Black Lung ID: _____
   b. Is Procedure covered (DX on DOLlist)? ---------- Yes ☐ No ☐
      If Yes: Date benefits began: ____ | ____ | ____ (MM | DD | YY)

IF TODAY'S visit is related to a Workers Comp or other non-related (NF/TPL) injury/illness, complete 10 or 11.

10. ***Is this injury/illness covered by a Workers Comp claim?*** ---------- ☐ Yes ☐ No
    a. Workers' Compensation Info: Injury date: ____ | ____ | ____ (MM | DD | YY)
       Claim #: _____ Policy #: _____
    b. Workers' Compensation
       Employer Address Info: Employer name: _____
       Address: _____
       City: _____ State: _____ ZIP: _____
    c. Workers' Compensation
       Plan Address Info: Employer name: _____
       Address: _____
       City: _____ State: _____ ZIP: _____
11. ***Is this illness • injury the result of a non work-related ACCIDENT?*** *(If "Yes", answer 11a - 11c If "No" go to 12)* Yes ☐ No ☐
    a. Accident Info:Accident type: _____
       Accident date: ____ | ____ | ____ (MM | DD | YY)
       Accident state: _____ Accident location: _____
    b. Is Non-Liability Insurance Information Available (i.e. No-Fault)? (If "Yes", answer below If "No" go to 11c) ---------- ☐ Yes ☐ No
       Insured name: _____
       Insurance company name: _____
       Address: _____
       City: _____ State: _____ ZIP: _____
       Policy #: _____ Claim #: _____
    c. Third Party Liability
       Insurance Info: Is someone else responsible? ---------- Yes ☐ No ☐
       If Yes: Responsible party's name: _____
       Does the patient have an attorney? (If "Yes", answer below If "No" go to 12) ---------- ☐ Yes ☐ No
       Attorney • Insurance company name: _____
       Attorney • Insurance company address: _____
       City: _____ State: _____ ZIP: _____ Phone: _____
       Policy #: _____ Claim #: _____
12. ***Are services covered by a Public Health Service or Research Program?*** *(If "Yes", answer 12a If "No" go to 13)* ☐ Yes ☐ No
    a. Program name: _____
       Program address: _____
       City: _____ State: _____ ZIP: _____
       Start Date: ____ | ____ | ____ (MM | DD | YY) End Date: ____ | ____ | ____ (MM | DD | YY)

13. ***Information supplied by (Name):*** _____ ***Date:*** ____ | ____ | ____ (MM | DD | YY)
14. ***Relationship to patient:*** _____

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