# MEDICARE SECONDARY PAYER (MSP) FORM

**Name:**

**Part I**

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|---|---|---|
| 1. Are you receiving benefits under the Black Lung Program?<br>If yes, date benefits began: ________________________________ | ☐ Yes | ☐ No |
| 2. Was this injury/illness due to a work-relatedaccident/condition?<br>If yes, date of injury/illness: ________________________________ | ☐ Yes | ☐ No |
| 3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?<br>If yes, date of accident: ___________________________________ | ☐ Yes | ☐ No |
| Is no-fault insurance available? | ☐ Yes | ☐ No |
| 4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending?<br>If yes, please provide:<br>Attorney's Name: ______________________________<br>Address: ______________________________<br>Phone Number: ______________________________ | ☐ Yes | ☐ No |

If you answered **NO** to all questions, go to Part II.

If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.

**Part II**

1. Are you entitled to Medicare based on? *Check the box that applies:*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – Go to **Part III**

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| 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?<br>If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage: | ☐ Yes | ☐ No |
| ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary. | ☐ Yes | ☐ No |
| ☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, your GHP is primary. | ☐ Yes | ☐ No |

**Part III**

*Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.*

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|---|---|---|
| 1. Do you have group health plan coverage? | ☐ Yes | ☐ No |
| 2. Are you within the 30-month coordination period? | ☐ Yes | ☐ No |

If yes to BOTH questions, GHP is primary during the 30-month coordination period

***Please provide a copy of your group health insurance if determined to be primary.***

| Signature of Patient/Representative: | Date: |
|---|---|

Relationship to Patient: