dermatology associates OF LINCOLN

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Medicare Secondary Payer Questionnaire – Short Form

Instructions: *Patients with Medicare must answer these questions before EVERY visit. If the answer is "Yes" to any of the below listed questions, have the patient complete the Medicare Secondary Payer Questionnaire – Long Form to help determine how services are to be billed.*

Date of Service: _____

1. Are you a military Veteran?
   a. Did the VA refer you here for treatment? □ Yes □ No
   b. Does the patient have a VA "fee basis ID card"? □ Yes □ No

2. Are you receiving Black Lung Benefits? □ Yes □ No

3. Is this medical condition due to an accident of any kind? □ Yes □ No
   a. If yes, was it:
      ○ Work Related □ Yes □ No
      ○ Automobile Accident □ Yes □ No
      ○ Injured in own home □ Yes □ No
      ○ Other: _____ □ Yes □ No

4. Are you covered by an employer's health insurance plan through your own employment or that of a family member? *(Not retiree coverage)* □ Yes □ No

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____ _____
Patient Name (Printed) **Legal Guardian Name (Printed)** **Relationship to Patient**