Surgery Clinic of Wellington
Sumner Regional Medical Center

Medicare Secondary Payer Questionnaire
(To be completed by Medicare Patients Only)

Name:_____
Date of Service:_____

(If the answer to questions 1a. through 4 is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

	Yes	No
1. Is the patient a Veteran?	___	___
a. Did the VA refer you here?	___	___
b. Does the pt have a VA "free basis ID card"?	___	___
2. Do you have a Federal Black Lung card?	___	___
3. Is the medical condition due to an accident?	___	___

If yes, was it: __ Work Related ___ Auto ___ Injured at Home ___ Other

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member?	___	___

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Shore at Sumner Regional Medical Center for any serviced furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administraion and its agents any information needed to determine these benefits or the benefits payable for related services.

DO NOT MAIL THIS FORM IN------Retain in Patient's File

_____ _____
Signature Date