SWEDISH

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)	Date of Birth

Medicare Number	☐ Part A ☐ Part B

MSP GENERAL INFORMATION *(Required for all Medicare Patients)*

1	**Is Medicare entitlement based on age?**	Yes	No
2	**Are you currently employed?**	Yes	No
3	**Is your spouse currently employed?**	Yes	No
4	**Are you covered by a health plan from you own or spouse's current employer?**	Yes	No
	→ Does the employer have 20 or more employees?	Yes	No
5	**Are you or your spouse retired?**	Yes	No
	→ Your retirement date: _____ / _____ / _____		
	→ Your spouse's name: _____		
	→ Your spouse's retirement date: _____ / _____ / _____		
6	**Are you entitled to Medicare because of end stage renal disease (ESRD)?**	Yes	No
	→ Are you within the first 30 months of treatment for ESRD?	Yes	No
7	**Are you entitled to Medicare because of disability, other than ESRD?**	Yes	No
	→ Are you covered by a group health plan of an employer with over 100 employees?	Yes	No
8	**Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today? (If yes, please provide authorization form)**	Yes	No
9	**Are you entitled to the benefits under the Federal Black Lung Program?**	Yes	No
10	**Is this illness/injury due to a work-related accident/condition?**	Yes	No
11	**Is this illness/injury the result of a non-work related accident (i.e. motor vehicle accident)?**	Yes	No
12	**Are you to be paid by a government research program? If yes, please provide billing instructions to the front desk**	Yes	No

Information supplied by	Relationship to Patient
	☐ Self ☐ Spouse ☐ Other _____

This form is intended for Medicare billing purposes only. If you have answered yes to any of the above questions or are receiving Medicare benefits due to Disability or ESRD more information will be required during your registration/check-in process.

Print Name	Date

Patient Signature

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).
注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

Official Use

Swedish NC 0003 ADMIN (Rev. 6/29/2018)

PLACE PATIENT LABEL HERE

Today's Date:

Patient Name:

MRN: Date of Birth: