ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Medicare Secondary Payer (MSP) Form

Patient Name: ____

Acct#: ____________________ **Medicare Number:** ______________________________

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1. Do you receive Veteran's benefits? Yes ☐ No ☐

2. Are you receiving benefits under the Black Lung Program? Yes ☐ No ☐

If yes, date benefits began ____________________

If yes, are the services you will be receiving related to a non-black lung condition? Yes ☐ No ☐

3. Was this injury/illness due to a work related accident/condition? Yes ☐ No ☐

If yes, date of injury/illness ______________________

4. Was the injury/illness related to an automobile accident? Yes ☐ No ☐

If yes, date of accident ____________________

5. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? Yes ☐ No ☐

If yes, please provide: Attorney's name: ______________________________

Address: ______________________________

Phone number: ______________________________

6. Are you entitled to Medicare based on: ☐ **Age (65 & over)—go to question 7**

☐ **Disability—go to question 7**

☐ **End Stage Renal Disease**

Do you have group health plan coverage? Yes ☐ No ☐

Are you within the 30 month coordination period? Yes ☐ No ☐

7. Are you currently employed? Yes ☐ No ☐ Date of retirement ____________________

a. Is your spouse employed? Yes ☐ No ☐ Date of retirement ____________________

b. Do you have a group health plan as primary coverage based on your own or a spouse's current (or former) employment? Yes ☐ No ☐

c. Does the employer that sponsors your group health employ 20 or more employees? Yes ☐ No ☐

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co: ______________________________________

Address: ______________________________________

Policy/Cert #: ______________________________________

Group name and number: ______________________________

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Signature of Patient/Representative **Date**

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Relationship to patient