PUEBLO OF JEMEZ HEALTH CLINIC

Medicare Secondary Payer Questionnaire

Patient's Name: _____ **HIC Number**:_____

Patient's DOB: _____ **Patient's Sex**: M F

Patient or spouse employed? **Yes** **No**

Name of Insurance Company: _____
Insured: _____ **Policy #:** _____
Employer: _____ **Phone #:**_____

Basis for patient entitlement to Medicare:
Age: _____ **Disability:**_____ **End Stage Renal Disease:**_____

Automobile, No-Fault, or Liability Insurance Information

Type of non-work related accident: **Automobile:** _____ **Other:** _____

Date of accident:_____ **Insurance: Liability** _____ **Not-liability:** _____

Name of Policyholder: _____
Address of Policyholder: _____
Policy Number or Claim Identification Number: _____
Name of Insurance Company: _____
Address of Insurance Company: _____
_____

Worker's Compensation Insurance Information

Date of Accident: _____

Is the patient working? **Full-time:** _____ **Part-time:** _____ **No:** _____

Patient's Name: _____ **Patient's DOB**: _____

Employer Name: _____
Employer Address: _____
City/State/Zip: _____

Name of Person or Company Insured: _____
Name of Insurance Company: _____
Insurance Company Claim or Policy Number: _____
Worker's Compensation Claim Number: _____

Name of Worker's Compensation Agency where claimed filed: _____
Address: _____
City/State/Zip: _____

Has the case been settled: Yes,_____, if so, Date: _____ No:_____

Other Governmental Coverage

Does the patient have coverage through:

a. _____**Veterans Administration (VA)**

b. _____**Black Lung Program (Department of Labor)**

c. _____**Other Federal or State Program**

d. _____**Government Grant Program**

Signature and Date

January _____ **July**_____

February _____ **August**_____

March _____ **September**_____

April_____ **October** _____

May _____ **November**_____

June _____ **December** _____