

Bascom Surgery Center
3803 S. Bascom Ave
Suite 106
Campbell, CA 95008
(408) 369-9535

Medicare Secondary Payer Questionnaire (Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung No Yes
Research Grant No Yes
Veteran Affairs No Yes

2. Was the illness/injury due to a work related accident/condition?

No Yes Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

No Yes Date of accident: _____

What type of accident caused the illness/injury?

Automobile Non-automobile

4. Are you entitled to Medicare based on:

Age Disability End Stage Renal Disease

5. Are you currently employed?

No Yes

6. Is your spouse currently employed?

No Yes

7. Do you have health insurance sponsored through your own or spouse's employer?

No Yes

8. Does the employer that sponsors your insurance plan employ 20 or more employees?

No Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?

(Long form not required. ALERT: If yes, bill SNF not Medicare)

No Yes

I confirm that the above information is correct.

Patient Signature: _____

Please Print Name: _____