MEDICARE SECONDARY PAYER DEVELOPMENT

NAME | MEDICARE ID

INSTRUCTIONS: This form will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. **USE BLACK OR BLUE INK.**

EXAMPLE | | A | B | C | | | 1 | 2 | 3 | | |

SECTION A - INFORMATION ABOUT YOU

1) Do **YOU** have any group health plan coverage based upon your current employment?
YES ☐ **NO** ☐ (If **NO,** go to **SECTION B**)

2) How many employees, including yourself, work for the employer from whom you have health insurance?
Don't Know ☐ **1-19** ☐ **20-99** ☐ **100 or More** ☐ (If **less than 20,** go to **SECTION B**)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

DATE INSURANCE COVERAGE BEGAN (M M – D D – Y Y Y Y) POLICY NUMBER

TYPE OF INSURANCE: HOSPITAL/MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY (DOCTOR/SUPPLIER) ☐

3) Does your group health plan cover prescription drugs? **YES** ☐ **NO** ☐ (If **NO**, go to **SECTION B**)
Please use your insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION B - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER

1) Do **YOU** have any group health plan coverage based upon your spouse's/other family member's current employment? **YES** ☐ **NO** ☐ (if **NO**, go to **SECTION C**)

2) How many employees, including your spouse/other family member, work for the employer from whom they have health insurance? **Don't Know** ☐ **1-19** ☐ **20-99** ☐ **100 or more** ☐
(If **less than 20,** go to **SECTION C**)

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SECTION B - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER, CONTINUED

Policy Holder/Subscriber's First Name

Policy Holder/Subscriber's Social Security Number ___ — ___ — ____

Policy Holder/Subscriber's Last Name

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

DATE INSURANCE COVERAGE BEGAN ___ — ___ — ____ (M M D D Y Y Y Y)

POLICY NUMBER

TYPE OF INSURANCE: HOSPITAL/MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY (DOCTOR/SUPPLIER) ☐

3) Does your family member/spouse's group health plan cover prescription drugs?

YES ☐ **NO** ☐ (If **NO**, **STOP**, go to **SECTION C**)

Please use your insurance card to provide the following information, if available:

Rx GROUP

Rx PCN

MEMBER ID

Rx BIN

SECTION C - MORE INFORMATION ABOUT YOU

1) Are **YOU** receiving **Black Lung** Benefits? **YES** ☐ **NO** ☐
2) Are **YOU** receiving **Workers' Compensation** benefits? **YES** ☐ **NO** ☐
3) Are **YOU** receiving treatment for an injury or illness which another party could be held **liable** or could be covered under **no-fault** or **auto insurance**? **YES** ☐ **NO** ☐

If **YOU** answered **YES** to any questions in this section, go to **SECTION D**
If **YOU** answered **NO** to **all** of these questions, sign below and return this form only.

Your Signature

AREA CODE ___ — PHONE NUMBER ___ — ____

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MEDICARE SECONDARY PAYER DEVELOPMENT, CONTINUED

NAME | MEDICARE ID

SECTION D - MORE INFORMATION ABOUT YOU

1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began.

M M — D D — Y Y Y Y

2) If **YOU** are now receiving any medical services related to an illness or injury which occurred on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date of illness or injury.

M M — D D — Y Y Y Y

Please provide information about the employer and the employer, insurance carrier, and attorneyin the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

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SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

3) If **YOU** are now getting any treatment for an illness or injury for which another party could be held **liable**, please print the date of illness or injury: M M — D D — Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault** or **automobile insurance**, print the date the of illness or injury: M M — D D — Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

Your Signature

AREA CODE PHONE NUMBER

OMB # 0938-0214