



AMBULATORY SURGERY CENTER OF SPARTANBURG

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 group health plan (GHP) coverage based on your own, or a spouse's, current employment?

No  Yes

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

No  Yes

I confirm that the above information is correct:

Patient Signature	
Please Print Name	