Hospice & Palliative Care of Greater Wayne County

MEDICARE SECONDARY PAYOR (MSP) SCREENING FORM

Ask all questions of each Medicare patient. If "YES" on any question, ask the other applicable questions in that section. NOTE: It is important to ask ALL questions and document ALL answers regarding Medicare Secondary Payor (MSP). HPC may be held liable if an overpayment occurs and Medicare finds HPC furnished erroneous information or failed to disclose facts it knew were relevant to payment. Have patient or representative sign this form.

1 Is the illness or injury due to ANY KIND of accident? ☐ NO (go to #2 below) ☐ YES (Medicare may be secondary-- continue with types of accidents below A-D)

A. ☐ Motor Vehicle: Date occurred__________ Name of Auto Insurer_________________

Insured person______________________________ Policy #____________________

B. ☐Work Related: Name of Workman's Comp Insurer_____________________________

C. ☐ Slip & Fall: Explain where fall occurred______________________________________

Did fall occur at place other than patient's home? ☐ NO (go to "D")

☐ YES (determine if liability claim or suit will be filed, or if any kind of compensation can be made) Give information on 3rd party/insurer____________________________________

D. ☐ Other accident, no third party can pay. Give description of accident and location______

____

2. Does the patient have coverage through the VA, Public Health Service, the Dept. of Labor's Black Lung or some other federal agency program? ☐ NO (go to #3) ☐ YES (the entity with which the patient has coverage must be billed as primary, Medicare as secondary)

3. Is the patient aged 65 or over? ☐ NO (go to #4) ☐ YES

- Is the patient employed? ☐ NO—Date of retirement_____/_____/_____ ☐ YES
- Does patient's employer employ 20 or more workers? ☐ NO (go to #3.A.) ☐ YES
- Does patient have an Employer Group Health Plan (EGHP)? ☐ NO (go to #6) ☐ YES--Obtain EGHP information and bill EGHP as primary, submit MSP bill to Medicare)

A. Is patient's spouse employed? ☐ NO--Date of retirement _____/_____/____ ☐ YES

- Does spouse's employer employ 20 or more workers? ☐ NO (go to #6) ☐ YES
- Does patient have an Employer Group Health Plan (EGHP)? ☐ NO (go to #6) ☐ YES--Obtain EGHP information and bill EGHP as primary, submit MSP bill to Medicare

4. Is the patient on Medicare solely because of a disability? ☐ NO (go to #5) ☐ YES (**for patients under age 65**)

- Is patient covered under any Group Health Insurance (includes insurance through spouse's employer)? ☐ NO (go to #5) ☐ YES--Obtain information and bill insurance as primary, submit MSP bill to Medicare.

5. Is the patient entitled to Medicare SOLELY because of End Stage Renal Disease (ESRD) AND in the first 12 months of Medicare? ☐ NO (go to #6) ☐ YES (**for patients under age 65**)

- Is patient covered under any Group Health Insurance? (Includes insurance through spouse's employer)? ☐ NO (go to #6) ☐ YES--Obtain information and bill as primary, submit MSP bill to Medicare.

6. Does the patient have ANY insurance other than Medicare? ☐ NO (you're done)

☐ YES—SEE PAYOR SOURCE SHEET

Patient/Representative Signature:____RN/LSW___________________

Hospice & Palliative Care of Greater Wayne County

2525 BACK ORRVILLE ROAD
WOOSTER, OHIO 44691
Phone: (330) 264-4899
Fax: (330) 264-4874

I understand that Hospice & Palliative Care of Greater Wayne County is a nonprofit organization providing palliative rather than curative care. I acknowledge that I have been provided a full understanding of the nature of hospice care. No one will be denied services because of inability to pay.

In order to bill your insurance company directly, Hospice & Palliative Care of Greater Wayne County needs your signature.

I authorize ____
(Insurance Carrier)

____ to pay benefits directly to
(Policy Number)

Hospice & Palliative Care of Greater Wayne County for all covered services under this policy and release medical records, including drug, alcohol, AIDS or AIDS related information. I understand that the reimbursement source listed above cannot release to anyone else any information received unless I specifically authorize such release.

______________________ **_______________________________________**
Date **Signature of Insured**

____
Signature of Hospice Representative

Patient Name: ______________________________ HPC# ______________

Claim Form Received & Signed: ____

Copy to Patient/Family_______