

Medicare Secondary Payer (MSP) Form Attachment A

Date:	
Patient Name:	
Medicare Number:	Provider Number: <u>050084</u>
1. Do you receive Veteran's benefits?	
2. Are you receiving benefits under the Black Lung Program?	
Yes; Date benefits began (MM/DD/CCYY)//	
□ No	
3. Was this injury/illness due to a work related accident/condition of the second state of injury/illness (MM/DD/CCYY)///	
4. Was this injury/illness related to an automobile accident? If yes, date of accident (MM/DD/CCYY)/	
5. Was this injury/illness related to an accident in which you inte	end to file a liability suit or litigation is pending? ☐Yes ☐ No
If yes, please provide: Attorney's name:	Phone:
Address:	
6. Are you entitled to Medicare based on: ☐ Age (65 & over). GO TO QUESTION #7 ☐ Disability. GO TO QUESTION #7 ☐ End Stage Renal Disease Do you have group health plan (GHP) coverage? ☐ You within the 30-month coordination period? ☐ You wish to the proof of the	_
 7. Are you currently employed? Yes No Date of retire a) Is your spouse currently employed? Yes No Date b) Do you have a group health plan (GHP) as primary coverage employment? Yes No c) Does the employer that sponsors your GHP employ 20 or meaning the control of the	of retiremente based on your own or a spouse's current (or forme
If you answered "Yes" to question #3, #4 or #7 above, please co	emplete the following information:
Insurance Co:	
Address:	
Policy/Cert #:	
Group Name and #:	
Patient's name:	
Responsible Party:	