TOTAL HEALTH & REHABILITATION, INC.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name_____ Date_____/_____/_____

1. Are you receiving benefits under the Black Lung Program? _____**Yes** _____**No**

2. Is illness/injury due to a work related incident covered by a Worker's Compensation Plan?

   _____**Yes** _____**No**

3. Is illness/injury due to a Motor Vehicle Accident? _____**Yes** _____**No**

4. Is illness/injury related to an accident in which you intend to file a liability suit or litigation is pending?

   _____**Yes** _____**No**

5. Are you entitled to benefits under the Department of Veteran Affairs?

   _____**Yes** _____**No**

   If Yes, has the Department of Veteran's Affairs authorized and agreed to pay for care at this facility?

   _____**Yes** _____**No**

6. Are you entitled to Medicare based on:

   Choose: (if applicable) _____Age (65 & Over) _____Disability _____End Stage Renal Disease (ESRD)

7. Are you Currently Employed? _____**Yes** _____**No**

   If No: Date of Retirement_____/_____/_____ or _____Never Employed

8. Is your spouse currently employed? _____**Yes** _____**No**

   If No: Date of Retirement_____/_____/_____ or _____Never Employed

9. Are you covered under a Group Health Program (GHP) through you or your spouse's current employment?

   _____**Yes** _____**No**

X_____ Date_____/_____/_____

Signature of Patient

9/12/2014 dlf