MSP Questionnaire

Patient Name: _____ **Date of Birth:** _____

Medicare #: _____ **Skilled Care (A)or Non-skilled (B)**_____

Eligibility Dates: _____

Are you receiving Medicare based on age?	**Yes**	**No**
Are you receiving Medicare based on disability?	**Yes**	**No**
Are you receiving Medicare SOLELY based on ESRD (End Stage Renal Disease)?	**Yes**	**No**
Are you entitled to Medicare on the basis of ESRD and age, or ESRD and disability?	**Yes**	**No**
Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?	**Yes**	**No**
Does the working aged or disability MSP provision apply (i.e. is the GHP primary based on age or disability entitlement?	**Yes**	**No**
Do you have a kidney transplant? **If yes, please include the date of the transplant _____**	**Yes**	**No**
Have you received maintenance dialysis treatments? **Date dialysis began (MMDDYY): _____**	**Yes**	**No**
Has it been 30 months since you were diagnosed with ESRD?	**Yes**	**No**
Are you retired?	**Yes**	**No**
If yes, Date of retirement (MMDDYY):		
Patient's Employer:		
Number of employees: >100 <20		
Phone #:		
Insurance Company:		
Address:		
Address:		
Is your spouse retired?	**Yes**	**No**
If yes, Date of retirement (MMDDYY):		
Patient's Employer:		
Number of employees: >100 <20		
Phone #:		
Insurance Company:		
Address:		
Address:		
Was patient injured due to a motor vehicle accident, fall in a public place fall at another party's home, or work related injury?	**Yes**	**No**
Accident Description:		
Location:		
Accident Date:		
Policy Holder Name:		
Insurance Co:		
Ins. Address:		
Ins. Address:		
Policy #:		
Agents Name:		
Agents Phone #:		
Did patient fall in own home?	**Yes**	**No**
Does patient have VA benefits?	**Yes**	**No**
Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?	**Yes**	**No**
Are you receiving Black Lung benefits?	**Yes**	**No**
Are the services to be paid by a government program such as a research grant?	**Yes**	**No**

Patient account Representative:
Information provided by: _____ **Relationship:** _____

MSP Completed by: _____ **Date:** _____