Patient Name: _____

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). LifeCare Hospice may be held liable if an overpayment occurs and Medicare finds LifeCare Hospice 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 entitlement ☐ 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

Part D Provider:	**Provider Phone #:**	**Patient ID #:**

Patient/Representative _____ **LifeCare Hospice Representative/Title**_____

LifeCare Hospice
1900 AKRON ROAD
WOOSTER, OHIO 44691
Phone: (330) 264-4899
Fax: (330) 264-4874

I understand that LifeCare Hospice is a nonprofit organization providing palliative rather than curative care. I acknowledge that I have been given 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, LifeCare Hospice needs your signature.

I authorize:

_____
(Insurance Carrier)

_____ to pay benefits directly to
(Policy Number)

LifeCare Hospice 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 Insured

_____
LifeCare Hospice Representative

Patient Name: _____ LifeCare Hospice# _____

Claim Form Received & Signed: _____

Copy to Patient/Family_____