



MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____
Elite Sports Medicine and Physical Therapy, LLC Acct # _____

Medicare # (exactly as on Red-White-Blue Government Medicare Card) _____

Please read and respond to each of the following:

1. Have you had any Home Health Care visits from any Home Health provider in the past 60 days? Yes or NO

If yes, please provide the name and phone number of the Home Health Agency:

Home Health Agency Name: _____

Home Health Agency Phone Number: _____

2. Was your illness/injury due to any of the following: Yes or No If yes, please indicate.

- Work-Related
- Automobile Accident
- Accident on Property (other than your own)
(Example: store, restaurant, etc.)

3. If Medicare coverage is due to age or disability, do you have group insurance coverage through another family member’s current employer?

- Yes – the group insurance will be primary
- No – Medicare will be primary

4. Do you have any benefits through TriCare (formerly Champus)? Yes or No

If you answered yes to questions 2 or 3 there is a second form to be filled out.

Patient’s Signature _____ Date _____