HealthCare Clinical Laboratories
A Dignity Health Member

Medicare Secondary Payer (MSP) Form
Attachment A

Date: _____

Patient Name: _____

Medicare Number: _____ Provider Number: 050084

1. Do you receive Veteran's benefits? ☐ Yes ☐ No

2. Are you receiving benefits under the Black Lung Program?

   ☐ Yes; Date benefits began (MM/DD/CCYY) __ __ /__ __/__ __ __ __

   If yes, are the services you will be receiving related to a non-black lung condition? ☐ Yes ☐ No

   ☐ No

3. Was this injury/illness due to a work related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness (MM/DD/CCYY) __ __ /__ __/__ __ __ __

4. Was this injury/illness related to an automobile accident? ☐ Yes ☐ No
   If yes, date of accident (MM/DD/CCYY) __ __ /__ __/__ __ __ __

5. Was this injury/illness related to an accident in which you intend 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? ☐ Yes ☐ No
   Are you within the 30-month coordination period? ☐ Yes ☐ No

7. Are you currently employed? ☐ Yes ☐ No Date of retirement _____
   a) Is your spouse currently employed? ☐ Yes ☐ No Date of retirement _____
   b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current (or former) employment? ☐ Yes ☐ No
   c) Does the employer that sponsors your GHP employ 20 or more employees? ☐ Yes ☐ No

If you answered "Yes" to question #3, #4 or #7 above, please complete the following information:

Insurance Co: _____

Address: _____

Policy/Cert #: _____

Group Name and #: _____

Patient's name: _____ Date: _____

Responsible Party: _____ Relationship: _____