Heritage Health and Physical Therapy, LLC
Medicare Secondary Payer (MSP) Form

Patient Name _____

Date _____

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

2. Are you receiving benefits under the Black Lung Program? Yes __ No __
   If yes, date benefits began _____
   If yes, are the services you will be receiving related to a non-black lung condition? Yes __ No __

3. Was this injury/illness due to a work related accident/condition? Yes __ No __
   If yes, date of injury/illness _____

4. Was this injury/illness related to an automobile accident? Yes __ No __
   If yes, date of accident _____

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: _____
   Address: _____
   Phone number: _____

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 questions #3, #4 or #7 above, please complete the following information:
Insurance Co: _____
Address: _____
Policy/Cert #: _____
Group name & #: _____

Patient Signature _____

Date _____

Revised: March 2014