Reynolds & Associates
Physical Therapy, Inc.

MEDICARE SECONDARY PAYOR SCREENING FORM

NAME:______________________________________

1. Are you covered under VA Medicare? ☐ yes ☐ no
2. Are you covered under Black Lung Medicare? ☐ yes ☐ no
3. If Medicare is your primary coverage and you have secondary coverage under another insurance company please complete the following if the secondary insurance is under someone else's name:
   a. Name of secondary insurance company:________________________________
   b. Name of insured other than yourself:__________________________________
   c. Is that person employed: ☐ yes ☐ no
      If yes, provide name, full address and phone number of their employer:
      ____
4. If you are retired, give your official retirement date:____________
5. If Medicare is your secondary insurance please give the following information:
   a. Name of primary insured:____
   b. Name and address of primary insurance company:_______________________
   c. Name and complete address of employer:
      ____
6. Is this condition related to an automobile accident? ☐ yes ☐ no
7. Is this condition related to a work accident? ☐ yes ☐ no
8. Any other type of accident for which another party may be held liable? ☐ yes ☐ no
9. Is this condition related to an accident in your home? ☐ yes ☐ no
10. If none of the above, please explain how this injury / diagnosis occurred?
    ____
    ____
11. If you answered yes to any of the above questions, please supply the following information:
    d. Date of accident:______________________
    e. Name and address of the responsible party:
       ____
    c. Date the other party's insurance was first billed__________________________
    f. Name, address and phone number of attorney if one is involved
       ____
    e. Give a brief description of the accident:________________________________
       ____
       ____

____ ______________________
Signature **Date**