Silicon Valley Surgery Center
14601 South Bascom Avenue, Suite 100
Los Gatos, CA 95032
408.402.0663

Silicon Valley Surgery Center

Medicare Secondary Payer Questionnaire
(Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung ____No ____Yes
Research Grant ____No ____Yes
Veteran Affairs ____No ____Yes

2. Was the illness/injury due to a work related accident/condition?

_____ No _____ Yes Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

_____ No _____ Yes Date of accident: _____

What type of accident caused the illness/injury?

_____ Automobile _____ Non-automobile

4. Are you entitled to Medicare based on:

_____ Age _____ Disability _____ End Stage Renal Disease

5. Are you currently employed?

_____ No _____ Yes

6. Is your spouse currently employed?

_____ No _____ Yes

7. Do you have health insurance sponsored through your own or spouse's employer?

_____ No _____ Yes

8. Does the employer that sponsors your insurance plan employ 20 or more employees?

_____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?
(Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____

Please Print Name:_____