Boulder Community Health

MSP Questionnaire

Patient Name: ________________________________ **Date of birth:** _____________ **Date:** __________

1. Are you receiving **Black Lung (BL) benefits**? ___ No ___ Yes*
2. Are any of your services to be paid by a **government research grant**? ___ No ___ Yes*
3. Are any of your services to be paid for by the **Dept of Veteran Affairs**? ___ No ___ Yes*
(Requires authorization from the VA to be seen at this clinic)
4. Are any of your services due to a work-related illness/injury for which a **Worker's Compensation** plan must be billed? ___ No ___ Yes*
5. Are any of your services due to an **automobile accident**? ___ No ___ Yes*

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6. **Are you entitled to Medicare based on your age (65 and over)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Are you currently **ACTIVELY** employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by your employer's group health plan? ___ No ___ Yes*
   - Does your employer employ 20 or more people? ___ No ___ Yes*

   b. Is your spouse currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by your spouse's employer's group health plan? ___ No ___ Yes*
   - Does your spouse's employer employ 20 or more people? ___ No ___ Yes*

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7. **Are you entitled to Medicare based on disability**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Are you currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by your employer's group health plan? ___ No ___ Yes*
   - Does your employer employ 100 or more people? ___ No ___ Yes*

   b. Is a family member (parent or spouse) currently employed? ___ No ___ Yes
   (**If YES**, please answer the following questions)
   - Are you covered by the family member's employer's group health plan? ___ No ___ Yes*
   - Does your family member's employer employ 100 or more people? ___ No ___ Yes*

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8. **Are you entitled to Medicare as a result of ESRD (End Stage Renal Disease)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
   a. Do you have group health plan coverage? ___ No ___ Yes
   b. Are you within the 30 month "coordination" period? ___ No ___ Yes
   If YES to both a and b, please answer the following questions:
   - Are you entitled to Medicare based on ESRD and age (65+)? ___ No ___ Yes

   If YES, please answer the following question:
   - Was your initial entitlement to Medicare based on age (65+)? ___ No ___ Yes
     *** If YES, please make sure to complete section 6, above ***
   - Are you entitled to Medicare based on ESRD and disability? ___ No ___ Yes

   If YES, please answer the following questions:
   - Was your initial entitlement to Medicare based on disability? ___ No ___ Yes
     ***If YES, please make sure to complete section 7, above ***

Patient Signature:____

Updated 5/2014