MEDICARE SECONDARY PAYER PROVISION-
WORKING AGED IN MISSOURI

JULY, 1986

CONTROL #P-07-86-00079

REGION VII
KANSAS CITY, MISSOURI

OFFICE OF ANALYSIS AND
INSPECTIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

CONTENTS

I. EXECUTIVE SUMMARY

The Kansas City Regional Office, Office of Analysis and Inspections (OAI) conducted a regional program inspection of Medicare secondary payer provisions as they relate to working aged under the Tax Equity and Fiscal Responsibility Act of 1982.

Intermediary data indicated there are 160 short-term hospitals in Missouri. Our inspection focused on the 30 largest hospitals since Intermediary data indicated that 73 percent of the working aged they had identified were in these hospitals. No review for working aged was made on the remaining 130 hospitals, where 27 percent of the working aged had been identified by the Intermediary.

Four hospitals in Missouri were selected for review in conjunction with the inspection on working aged. Blue Cross Hospital Services, Inc., of Missouri prepared for our office a listing of all inpatient beneficiaries in these hospitals who were aged 65-69 in 1983-1984. The Intermediary identified 3830 beneficiaries with 5789 discharges. A randomly selected sample of 75 beneficiaries from each hospital were identified. The total of 300 beneficiaries generated a total of 449 discharges at the four hospitals. A total of 11 beneficiaries or their spouses with a total of 13 discharges were identified as being working aged within the TEFRA definition.

Comparative data indicated that the four sample hospitals and the 30 hospitals in the universe had similar characteristics in functional areas reviewed. These four hospitals, therefore, would be considered representative of the 30 hospitals for purposes of projecting an overpayment.

Based on our inspection covering 1983-1984, a projected overpayment of $5,023,759 was made by the Medicare program as the primary payer. Employer group health plans should have been the primary payer with Medicare being billed as the secondary payer.

We recommend that the HCFA Regional Office require the Missouri Medicare contractors to implement current guidelines according to Federal regulations, to ensure correct Medicare payments and to initiate recovery action for all improper payments, retroactive to January 1, 1983.

Comments were received from HCFA, the Intermediary, and the two Carriers servicing Medicare beneficiaries in Missouri. These comments indicated a general agreement with the findings and recommendations contained in the report. All responses demonstrated a recognition that problems existed during the 1983-1984 review period. HCFA and the contractors have taken steps to implement the recommendations, in whole or in part, within the limits of budgetary constraints. Acknowledgment was made that improvement is needed and the responses indicated HCFA and the contractors are working to improve procedures for the identification and processing of claims related to working aged.

II. INTRODUCTION

This report details the findings and recommendations that resulted from the program inspection of Medicare Secondary Payer Provisions--Working Aged in Missouri--conducted by the Office of Analysis and Inspections, Office of Inspector General, Kansas City Regional Office.

The inspection program was developed and implemented by the Office of Analysis and Inspections. The inspections are a major function of OAI as part of its responsibility to minimize the opportunity for fraud, abuse, and waste in DHHS programs. Specifically, program inspections are reviews which:

(1) Examine specific program operations and/or reimbursement policies and the manner in which they are implemented to determine if they are contributing to fraud, abuse or waste, and

(2) Demonstrate the significance of the inefficient or ineffective policy or method of implementation and recommend changes which would improve program administration, contribute to ensuring proper services are provided to eligible beneficiaries and/or save program dollars.

The format of this program inspection report is of an exception type; in that, only areas requiring improvement are presented. No conclusions regarding the overall level of an organization's performance should be drawn solely from this report.

III. SCOPE OF REVIEW

The Tax Equity and Fiscal Responsibility Act of 1982, provided that Medicare would be the secondary payer in cases where medical care can be paid by an Employer Group Health Plan. This would affect those beneficiaries or their spouses, who were working, were aged 65-69 and were a member of a Plan covering those persons.

Federal Regulations implementing this law were published in 42 CFR 405.340-344 on April 13, 1983. The regulations state that, effective for services furnished after 1982, Medicare benefits (Part A and B) are secondary to benefits payable by an employer group health plan for any month in which an individual age 65 through 69:

(1) Is entitled to Part A benefits.

(2) Is either employed or the spouse is employed and covered under an employer group health plan.

(3) The employer has 20 or more employees.

Medicare will be primary payer where:

(1) The individual is not covered under an employer group health plan including refusal to accept the employer's plan.

(2) Payment is not applicable by an employer group health plan for Medicare covered services.

(3) Secondary payments will be made to supplement the primary benefits paid by the employer group health plan if that plan pays only a portion of the charge for the services.

This program inspection was conducted to determine if HCFA and its Medicare contractors were correctly identifying Medicare secondary payer situations. A listing of beneficiaries furnished by the Intermediary contained 3830 beneficiaries, aged 65 through 69, having 5789 discharges, who had been inpatients at four Missouri hospitals. This listing was used to obtain a randomly selected sample of 300 beneficiaries, aged 65 through 69, who had generated 449 discharges.

Onsite visits were made to four Missouri hospitals to obtain admission and payment data. In addition, beneficiary history listings were obtained on the individuals in the sample who had services billed to Medicare during the review period. Beneficiary histories were obtained from Blue Cross Hospital Services, Inc., of Missouri, General American Life Insurance Company and Blue Shield of Kansas City. Eleven beneficiaries or their spouses generating 13 discharges were identified as working aged within the definition in TEFRA.

Based on data from the Intermediary there are 160 short term hospitals in Missouri. Intermediary data also indicated that 73 percent of the working aged were identified in the 30 largest hospitals. Our inspection involved four of the 30 hospitals within this group and the projected overpayment is based on these 30 hospitals. Although 27 percent of the working aged identified by the Intermediary were in hospitals under 300 beds, no attempt was made in this report to project an overpayment to these smaller hospitals.

IV. FINDINGS AND RECOMMENDATIONS

Finding 1

Medicare Paid as Primary Payer for Working Aged

The inspection found that out of 300 beneficiaries generating 449 discharges, aged 65-69, in our sample, 11 beneficiaries having 13 hospital discharges were working or their spouses were working under employer group health plans. These 13 discharges from the 11 beneficiaries had not been identified by the Intermediary or hospital as working aged before payment had been made.

The 300 beneficiaries represented 449 discharges for the four hospitals in the sample. The sample of beneficiaries/discharges was obtained from a universe of 3830 beneficiaries with 5789 hospital discharges.

Comparative data was obtained and analyzed for the four sample hospitals and the 30 hospitals in the universe. Functional areas reviewed indicated that the sample hospitals and the universe of hospitals compared similarly in every category. Therefore, these four hospitals would be considered representative of the 30 hospitals for purposes of projecting an overpayment.

Based on the data obtained from the Medicare contractors, a Medicare Part A and B overpayment of $40,855 is calculated for services rendered related to these 13 hospital discharges. Projecting the sample to the entire population, aged 65 through 69, in all 30 hospitals for the review period for whom services were billed, overpayments of $5,023,759 were made by the Medicare program.

Recommendation

We recommend that HCFA instruct the Medicare contractors indicated in this report to review all services provided resulting from working aged coverage since January 1983. Applicable recovery should be made from third party payers or from providers.

Finding 2

Greater Detection Capability Needed By Intermediary Secondary Payer Unit

The Intermediary had an established Secondary Payer Unit when the program inspection was conducted. The Unit had identified one of the beneficiaries as a Medicare secondary payer situation after payment had been made. With respect to this beneficiary, the inspection team identified three additional periods of hospitalization not identified by the Secondary Payer Unit.

Recommendation

We recommend that HCFA instruct the Medicare contractors to establish or improve existing Secondary Payer Units to more effectively identify Medicare secondary payer situations involving working aged.

Finding 3

Improvement Needed By Hospitals in Obtaining Working Aged Information

Hospitals are not adequately obtaining critical information in order to identify working aged beneficiaries or their spouses. Deficiencies noted were:

(1) Lack of any information regarding employment status.

(2) Date as to when employee or spouse retired. This information would give the validity of the time period covered under EGHP.

(3) Age of the spouse would have indicated that the spouse was aged 65 and over and could have qualified as working aged.

(4) Information obtained on other insurance or employment related insurance forms is not being transferred to the billing form submitted to the Intermediary. The Intermediary is thereby unaware of possible EGHP coverage.

Recommendation

HCFA should ensure that Medicare contractors assist hospitals in obtaining essential information to identify working aged themselves or that sufficient information is given Intermediaries to identify working aged.

Finding 4

Lack of Coordination Between Intermediary and Carriers on Exchange of Information

Intermediary and Carrier guidelines were reviewed to determine the extent of coordination for pertinent information on working aged. Review of the contractors records indicates that information on working aged available to the Intermediary may have assisted in preventing payment being made by the Carrier.

Recommendation

HCFA should assure necessary exchange of potential working aged data among contractors which would prevent overpayments from being made.

V. TABLE SUMMARIZING DOLLAR EFFECT OF REPORTED FINDING

Overpayment Projection of
Medicare Secondary Provision

Medicare Contractor	Amount Paid in Sample	Projected Overpayment
Blue Cross Hospital Service, Inc., of Mo.	$29,792	$3,663,337
General American Life Insurance Company	600	73,782
Blue Shield of Kansas City	10,463	1,286,640
	$40,855	$5,023,759

VI. SUMMARY OF COMMENTS SOLICITED AND RESPONSES

Comments were received from the Health Care Financing Administration as well as the Part A Intermediary and two Part B Carriers servicing Missouri.

Health Care Financing Administration

HCFA commented that the recommendations contained in the report are appropriate for the review period, which was 1983-1984. HCFA indicated the various steps that have been taken to more effectively implement the working aged provisions of the Medicare law. This includes: (1) the recovery of funds from known employer group health plans, (2) the preparation of a mass mailing to beneficiaries to obtain MSP information, (3) educational efforts particularly with hospitals and, (4) preparation of lists of beneficiaries covered by EGHP to be shared with Carriers.

Blue Shield of Kansas City

The Carrier is concentrating its Medicare Secondary Payer activities on Fiscal Year 1986, for which it has goals to meet. The Carrier expressed reluctance to pursue any prior MSP/EGHP situations because of lack of funding to conduct any necessary investigations. In fact, if the Intermediary were to compile a listing of beneficiaries with known EGHP coverage, it would not be utilized anyway by the Carrier because of a lack of funding to conduct the required investigations.

General American Life Insurance Company

The Carrier commented that the draft report probably gives a reasonably accurate picture of the MSP--Working Aged situation during the 1983-1984 review period. The Carrier stated that the 1984 national MSP workshop and the 1985 regional MSP workshop have had a significant impact upon improving MSP program activities. The Carrier sees continued improvement in the MSP area because of better procedures and periodic workshops, both at the national and regional levels.

Blue Cross Hospital Service, Inc., of Missouri

The Intermediary recognizes the problem that still exists with respect to MSP working aged as evidenced by the large number of claims being processed by Medicare as primary rather than as secondary payer. The MSP unit is being updated to enable it to have automated processing capabilities.

The Intermediary is planning to use a beneficiary questionnaire to detect MSP/EGHP situations dating back to 1983. Also, information obtained through suspension of claims because of Y-Trailer data will be utilized to identify potential MSP working aged cases. The Intermediary is aware of the need for better Intermediary/Carrier communication. Lists of beneficiaries will be made available to the Carrier for their use in developing potential MSP cases with EGHP involvement.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date: June 5, 1986

From: Gene Hyde
Regional Administrator
HCFA, Kansas City

Refer to:
PTAB:JOS
2.683

Subject: Draft Report on Medicare Secondary Payer (MSP) Working Aged in Missouri

To: Director, Office of Inspector General
Office of Health Financing Integrity
1100 Main Street
P.O. Box 26248
Kansas City, Missouri 64196

Attached are copies of contractors' replies to the findings and recommendations in your report. In general, I believe the recommendations to be appropriate to the MSP situation as it existed during the period covered in your report, 1983-1984. The recommendations are not fully appropriate to the situation as it exists now in 1986. This opinion is based on the belief that 1) some of the recommendations have been implemented in full or in part since 1983 and 2) budgetary constraints do not presently permit extensive MSP development on cases prior to 1984. Following are specific comments on your recommendations, in the order these appear in your report.

Recommendation 1

You recommend "that HCFA instruct the Medicare contractors indicated in this report to review all services provided resulting from working aged coverage since January 1983." The intent of this statement is interpreted to mean contractors should review Medicare reimbursements for medical services covered under employer group health plans. You also recommend that applicable recovery should be made from third party payers or from providers.

Response to Recommendation 1

Medicare contractors are recovering funds where it is known that coverage also exists under employer group health plans. However, this activity is costly and is currently funded at a level designed to meet MSP goals established for 1986. In addition to funding impediments there is a problem of identification, which is discussed in the response below. The intermediary targeted by your report intends to pursue recoveries back to 1983 after it has the benefit of automated MSP processing and the replies to beneficiary questionnaires have been compared to information in prior history. These two actions are now expected to be operational in late June, 1986. Further information on this point may be found in the letter dated May 14, 1986, from Blue Cross (copy attached).

Recommendation 2

You recommend that HCFA instruct the Medicare contractors to establish or improve existing Secondary Payer Units to more effectively identify Medicare secondary payer situations involving working aged. This recommendation springs from the finding that the intermediary apparently effectuated MSP recovery in one instance but failed to identify three additional periods of hospitalization for this same beneficiary which were covered at the time under an employer group health plan.

Response to Recommendation 2

HCFA is preparing a mass mailing to beneficiaries to elicit MSP information. The replies will be returned to one point in the country, the results tabulated and specific beneficiary data communicated to the appropriate contractor. The contractor will then be required to apply this information to beneficiary history and to make recoveries where overpayments are discovered. This activity is expected to begin within a few weeks. After this program becomes operational it should also serve to prevent future Medicare overpayments.

In the absence of automated programs which allow the application of known MSP information to subsequent claims/bills, the contractor must depend on the provider of services to identify MSP cases on each bill or claim. The intermediary described in your report has noted that it receives inconsistent information from providers and, therefore, is implementing use of a beneficiary questionnaire. The results of this questionnaire will be incorporated into automated systems so as to identify all other MSP situations on the beneficiary's account. When operational, this system should correct the problem described in your report.

Recommendation 3

You recommend that HCFA ensure that Medicare contractors assist hospitals in obtaining essential information to identify working aged individuals.

Response to Recommendation 3

Considerable educational effort has been made by contractors since 1983 and most of this has been directed to hospitals. However, due to staff turnover in the billing and admitting departments, hospitals may easily and quickly return to poor performance in identifying MSP situations which, presently, require beneficiary co-operation at least one or more times in the identification process.

HCFA is preparing to implement data exchange agreements with workmen's compensation agencies. While these are intended to result in obtaining leads to MSP situations involving workmen's compensation, this project will concurrently provide additional leads to working aged cases. In this way, HCFA will have one more alternative to beneficiary reporting by which to identify working aged situations. These agreements are under negotiation now and are expected to be operationally productive before October 1, 1986.

Recommendation 4

HCFA should assure necessary exchange of potential working aged data among contractors which would prevent overpayments from being made.

Response to Recommendation 4

The intermediary reports that a list is being compiled of beneficiaries who have EGHP coverage. This will be sent to the carriers and should serve to prevent recurrence of the problem you have noted.

Also, HCFA is presently assessing a demonstration project in another region, wherein all MSP information is maintained by one intermediary and all other contractors in that state tap into this repository via query processes. If successful, HCFA may mandate implementation of similar procedures in other regions.

Gene Hyde

Gene Hyde

Attachment

Blue Cross
Blue Shield
of Kansas City

3637 Broadway
P.O. Box 169
Kansas City, Missouri 64141

General Office 816/561-2300

May 19, 1986

William E. Fisher, Chief
Policy & Technical Assistance Branch
Division of Program Operations
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Fisher:

At you request, below please find our comments on the OIG MSP report:

Finding #1

Our MSP area is currently funded at a level designed to meet the MSP goals established for the Fiscal 1986 year. Consequently, our efforts are currently being directed at savings on claims processed during the current fiscal year. Investigation of services rendered since January 1983 would be impossible given current funding levels. Additionally, many carrier health insurance contracts have timely filing provisions which may prohibit reimbursement of old claims. It is possible that the investigation could be completed, only to find out that the contract prohibits payment of the claim.

Finding #4

Once again, lack of adequate funding has prevented us from utilizing the experience of the intermediary investigations for MSP.

If you have any questions on the above information, please contact me.

Sincerely,

Roger E. Crain
Vice President, Claims

Medicare / General
Part B / American

P.O. Box 505
St. Louis, MO 63166
Phone: (314) 843-8880
Toll free: 1-800-392-3070

May 15, 1986

Mr. William E. Fischer, Chief
Policy & Technical Assistance Branch
Division of Program Operations
Federal Office Building, Room 225
601 East 12th Street
Kansas City, MO 64106

RE: PTAB:JOS
2.680

Dear Mr. Fischer:

Thank you for the opportunity to comment on the OIG draft report of findings concerning Medicare Secondary Payer - Working Aged in Missouri.

The OIG study was based on a period when, admittedly, the MSP program was not doing well. This program began to pick up after the 1984 national MSP workshops, and we feel it has been improving steadily since. The 1985 workshop at the Regional Office helped the program to progress. At the 1986 MSP workshops, the indication was that HCFA was more than pleased with the results achieved to date. If a study were made for the current period, the results would not show the MSP-Working Aged program to be working perfectly, but it certainly would show the program to be much more effective than it was in 1983/1984, the period of this study.

We reviewed the study. It probably provides a reasonably accurate picture of the MSP-Working Aged situation during the 1983-1984 period. We are not sure of the value of a study that shows how this program was functioning two to three years ago - in it's infancy, so to speak.

We feel that we, along with all other carriers have made significant progress in the MSP program during the last two years. We continue to work at improving our procedures and in becoming more effective. Periodic regional and national workshops have played a very useful part in this improvement. The "recommendations" in the report have been implemented already in our opinion.

Sincerely yours,

Clifford A. Kinnunen
Manager
Medicare Benefits II

CAK:mtd

PTAB

Blue Cross Medicare

Federal Medicare Intermediary

4444 Forest Park
St. Louis, Missouri 63108-2292

May 14, 1986

Health Care Financing Administration Regional Office
ATTN: William E. Fischer, Chief PTAB - DPO
Room 225
601 E. 12th Street
Kansas City, Missouri 64106

RE: OIG Draft Report of Medicare Secondary Payer Provisions - Working Aged in Missouri

Dear Mr. Fischer:

This letter is in response to the above-referenced summation concerning the processing of working aged claims by the Medicare Part A Intermediary and the Part B contractors in Missouri.

Our office has thoroughly reviewed the findings and recommendations of the Kansas City Regional Office, Office of Analysis and Inspections (OAI) on MSP provisions regarding claims involving the working aged and TEFRA, 1982. We are aware that a large number of claims are being processed by Medicare as primary instead of secondary payer. Our office is also aware of the problem that exists in the identification of claims involving employer group health plan coverage by both the Intermediary and the provider community. Currently, our MSP Unit is still operating on a manual basis. A target date of June 1, 1986 has been set in which we will have automated processing capabilities which will allow us more time to review claims on a prepaid basis for possible employer group health plan involvement. It is also apparent to us that members of the provider community are inconsistent in gathering and relaying MSP information to our office due to incorrect or lack of information. Consequently, Medicare payment is being made for some services for which Medicare payment should be secondary.

For these reasons, our office is considering a new approach which would require that the Intermediary get verification from the beneficiary for claims in which primary payer responsibility has not yet been established (the source of this verification will be the claims suspended due to a "y-trailer suspect" error message during the processing function). The information will then be relayed to the providers of service who will be instructed to annotate their records accordingly and bill the appropriate payer for future billing purposes.

The following is our response to the findings and recommendations of the OAI. Our plans for the areas in improvement as cited by the OAI are stated in these responses.

Response to the recommendations on Finding #1:

After establishing the beneficiaries with EGHP coverage through the questionnaire, (see response to recommendations for Findings 2 and 3) the MSP Unit will research back to 1983 for claims paid by Medicare for which reimbursement from the EGHP will be sought.

Response to the recommendations on Findings #2 and #3:

The MSP Unit has discovered, through its observation of provider submitted data, what appears to be an inconsistency among all providers to correctly and routinely collect and report primary payer information. It is for this reason that the MSP Unit has developed a questionnaire that covers all primary payer situations. Using claims suspended as a result of y-trailer information on the inpatient/outpatient query replies, the MSP Unit will send this questionnaire directly to the beneficiary if the questionnaire has not been submitted previously. The response to the questionnaire will be filed into a report on a personal computer. Each subsequent claim record with a y-trailer will then be suspended and reviewed against the personal computer report. If the report shows a primary payer other than Medicare, the claim will be deleted and returned along with a printout of the returned questionnaire from the beneficiary and will be returned to the provider with instructions to:

1. Bill the identified primary payer and then resubmit the bills showing this information and,

2. Keep the printout in their files for future billing reference.

The date on which this information is submitted to the provider will also be recorded on another report. Subsequent claims billed to Medicare as primary when the provider has previously been informed of Medicare status as secondary will be noted in the file and the provider will be advised that this information was previously submitted to them. Subsequent and repeated billings of Medicare as primary by the provider which is aware that Medicare is secondary will result in an MSP on-site audit of that provider. Records of this will also be forwarded to the Health Care Financing Administration Regional Office to make them aware of the providers displaying inappropriate billing procedures and lack of cooperation with our office. Any future action to correct the providers will be decided at that point.

Response to the recommendations on Finding #4:

> The MSP Unit is aware of the need for better communication between Intermediary and carrier. At present time, a list is being compiled of beneficiaries that have EGHP coverage. This list will be sent to General American Life Insurance Company and Kansas City Blue Cross/Blue Shield.

We are optimistic that this approach should reduce the number of claims currently processed by Medicare as primary by increasing our capability to detect secondary payer claims on a prepay basis.

Sincerely,

Deborah Leitch for
Robert G. Davis
Director, Contract Administration
Government Programs Division

RGD:DS:smm

Blue Cross

Medicare

Federal Medicare
Intermediary

4444 Forest Park
St. Louis, Missouri 63108-2292

FORM APPROVED
OMB NO. 0938-0214

RE: Medicare Secondary Payer Questionnaire

Dear Medicare Beneficiary:

As you may well be aware by now, Medicare no longer makes first (primary) payment for all hospital or medical services rendered to Medicare beneficiaries. Primary payment for some services may be the responsibility of another source, such as:

- Automobile, liability, no fault or medical insurance
- Employer group health plan coverage for beneficiaries between the ages of 65 thru 69 or through their spouses under the age of 70
- Employer group health plan coverage for beneficiaries entitled to Medicare solely on the basis of end stage renal disease
- Workers Compensation benefits
- Black Lung benefits
- Veterans Administration benefits

Our office has been informed that one (or possibly more) of the primary payers listed above may have the responsibility of making first (primary) payment for your hospital and medical needs. Therefore, we are sending the attached Medicare Secondary Payer Questionnaire and ask for your full cooperation in completing all questions that may apply to you. Please return this form to my attention in the business reply envelope that is enclosed for your convenience.

Our office will then enter your information into our records and advise the providers of service of this information so that they can bill the appropriate party first.

If you have received hospital or medical services recently, you may have already been asked these questions by the hospital personnel. We appreciate any cooperation that you may have given to the hospital personnel regarding this matter. However, we still request that you complete this questionnaire and return it to our office at your earliest convenience.

Should you have any questions regarding this questionnaire, please feel free to contact our office.

Sincerely,

Medicare Secondary Payer Unit
Government Programs
Contract Administration

Blue Cross

Medicare

Federal Medicare
Intermediary

4444 Forest Park
St. Louis, Missouri 63108-2292

FORM APPROVED
OMB NO. 0938-0214

QUESTIONNAIRE FOR MEDICARE SECONDARY PAYER INFORMATION

BENEFICIARY NAME _____

HIC # _____

SECTION I.

AUTO, LIABILITY, NO FAULT, MEDICAL, MALPRACTICE COVERAGE

A. Date of accident _____
B. City, State _____
C. Attorney (Yes/No) If yes, complete 1-4
   1. Name _____
   2. Address _____
   3. City, State, Zip Code _____
   4. Telephone _____
D. Has claim been filed under your insurance? (Yes/No)
   If yes, complete 1-6
   1. Name of Insurance _____
   2. Address _____
   3. City, State, Zip Code _____
   4. Telephone _____
   5. Agent _____
   6. Policy # _____
   7. Claim Number _____
E. Has claim been filed under other party's insurance? (Yes/No)
   If yes, complete 1-9
   1. Name of Insurance _____
   2. Address _____
   3. City, State, Zip Code _____
   4. Telephone _____
   5. Agent _____
   6. Claim Number _____
   7. Insured Party _____
   8. Policy Number _____
   9. Claim Number _____
F. Have you already received settlement? (Yes/No) If yes,
G. What was settlement amount? _____
H. If yes to (F.), have you applied any of your settlement to accident related expenses, either hospital or medical? (Yes/No)
   1. If yes, submit copies of receipts, cancelled checks, money orders, etc. to verify payments.

I. If no to (F.), please explain why you did not apply settlement to accident related expenses, either hospital or medical.
J. Are you still undecided about whether or not to file a claim? (Yes/No)
K. Did accident occur in place of residence? (Yes/No) If yes,
   1. Is residence owned by you? (Yes/No)
      If no, did you file a claim for your injuries? (Yes/No) If yes,
   2. Name of Owner's Insurance _____
   3. Address _____
   4. City, State, Zip Code _____
   5. Agent Name _____
   6. Policy Number _____
   7. Claim Number _____

If you are also between the ages of 65 and 69, please be sure to complete Section II.

SECTION II.

EMPLOYER GROUP HEALTH PLAN COVERAGE (BENEFICIARIES BETWEEN 65-69 AND THEIR SPOUSES UNDER 70)

A. Are you employed? (Yes/No) If yes,
B. Does your employer employ 20 or more people? (Yes/No) If yes,
C. What is your present age? _____
   1. Name of Employer _____
   2. Address of Employer _____
   3. City, State, Zip Code _____
   4. Group Name _____
   5. Group Number _____
   6. Policy Number _____
   7. Telephone Number _____
D. Are you entitled to Part B Medicare only? (Yes/No)
E. Is your spouse employed? (Yes/No) If yes,
F. Does his/her employer employ 20 or more people? (Yes/No) If yes,
G. What is his/her present age? _____
   1. Name of Employer _____
   2. Address of Employer _____
   3. City, State, Zip Code _____
   4. Group Name _____
   5. Group Number _____
   6. Policy Number _____
   7. Telephone Number _____
H. Is he/she entitled to Part B Medicare only? (Yes/No)

SECTION III.

EMPLOYER GROUP HEALTH PLAN COVERAGE FOR BENEFICIARIES ENTITLED TO MEDICARE SOLELY ON THE BASIS OF END STAGE RENAL DISEASE

A. Are you employed? (Yes/No) If yes,

1. Name of Employer _____
2. Address _____
3. City, State, Zip Code _____
4. Group Name _____
5. Group Number _____
6. Policy Number _____
7. Telephone Number _____

B. Effective Date of Medicare Entitlement
   1. Part A _____ Part B _____
   2. First month in which you started regular course of dialysis training _____
   3. Between the month in which you started a regular course of dialysis training (#2.) and the Part A/B Medicare entitlement effective dates (#1.), did you receive:

      1. Self Dialysis Training (Yes/No)
         If yes, state month _____
      2. Renal Transplant (Yes/No)
         If yes, state month _____

C. Is this your first period of entitlement to Medicare solely on the basis of end stage renal disease? (Yes/No) If no, list all prior periods of entitlement.

From Part A _____ From Part B _____
To Part A _____ To Part B _____

From Part A _____ From Part B _____
To Part A _____ To Part B _____

D. Have you been employed previously but are no longer working? (Yes/No)
   If yes, give date/year of last month worked.
E. As of this writing, have you attained the age of 65?

SECTION IV.

WORKERS COMPENSATION COVERAGE

A. Date of accident _____
B. City, State _____
C. Attorney? (Yes/No) If yes, complete 1-4
   1. Name _____
   2. Address _____
   3. City, State, Zip Code _____
   4. Telephone _____
D. Have you filed a claim for your injuries? (Yes/No) If yes, complete 1-9
   1. Name of Insurance _____
   2. Address _____
   3. City, State, Zip Code _____
   4. Telephone Number _____
   5. Agent _____
   6. Claim Number _____
   7. Policy Number _____

8. Group Name _____
9. Group Number _____

E. Employer Information
1. Name _____
2. Address _____
3. City, State, Zip Code _____
4. Group Name _____
5. Group Number _____
6. Policy Number _____
7. Telephone Number _____

F. Name of Workers Compensation Board
1. Address _____
2. City, State, Zip Code _____
3. Person Handling Claim _____
4. Telephone Number _____

G. Have you already received settlement amount? (Yes/No) If yes,

H. What is settlement amount? _____

I. If yes to (G.), have you applied any of your settlement to accident related expenses, either hospital or medical? (Yes/No)
If yes, submit copies of receipts, cancelled checks, money orders, etc. to verify payments.

J. If no to (G.), please explain why you did not apply settlement to accident related expenses, either hospital or medical.

K. Are you still undecided about whether or not to file a claim with the State Worker Compensation Board? (Yes/No)

If you are between the ages of 65 and 69, please complete Section II.

SECTION V.

BLACK LUNG BENEFITS THROUGH THE DEPARTMENT OF LABOR

A. Are you currently or have you ever been entitled to Black Lung benefits? (Yes/No) If yes,
1. Entitlement Date _____
Termination Date _____

If you are between the ages of 65 and 69, please complete Section II.

SECTION VI.

VETERANS ADMINISTRATION BENEFITS

A. Are you currently or have you ever been entitled to Veterans Administration Benefits? (Yes/No) If yes,
1. Entitlement Date _____
Termination Date _____

If you are between the ages of 65 and 69, please complete Section II.