Specimen Referral to Bassett Healthcare Network

Please fill in all areas that apply. This information is necessary to properly process the sample.

Patient Information (print)

Patient Name _____ Date of Birth _____
Maiden or Previous Names _____ MIBH MR # _____
Sex M F Social Security # _____
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Residence Address _____ City _____
Mailing Address _____ City _____
State _____ ZIP Code _____ County _____
Home Phone _____ Work Phone _____
Occupation _____ Employer Name _____
Employer Address _____
Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled
☐ Retired – if so, date retired _____(mm/dd/yr) and fill out above for last employer

Specimen Information:

Specimen Date Referring Agency Visit Number

Diagnosis Diagnosis Code

Ordering and/or Attending Provider Provider Address

SNF PATIENT SERVICES

Name of Skilled Nursing Facility County

Mailing Address City State Zip code

Is the patient covered by Medicare Part A PPS ☐ Yes ☐ No (if no, please supply billing information below)
Is the patient covered by Medicare Part B PPS ☐ Yes ☐ No (if no, please supply billing information below)

BILLING INFORMATION (print) MUST SEND COPIES OF INSURANCE CARDS – BOTH SIDES

PERSON RESPONSIBLE FOR BILL (required if patient is a minor)

Guarantor Name _____ Date of Birth _____
Patient's relationship to guarantor _____ Guarantor's Social Security Number _____
Residence Address _____ City _____
Mailing Address _____ City _____
State _____ ZIP Code _____ County _____
Home Phone _____ Work Phone _____
Occupation _____ Employer Name _____
Employer Address _____
Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled ☐ Retired

Please check box if: **Patient is self pay** ☐ **Patient has In Lieu Of Medicare Product** (enter in ins. Info. below) ☐

Medicare: (MUST complete MSP information on back)
A B or A + B Certificate Number Effective Date
Medicaid Number:
Certificate Number Sequence Number: Effective Date

OTHER INSURANCE (In order of submittal)

1st Insurance Company Name _____
Address _____
Policy Number _____ Group Number _____ Plan _____
Subscriber's Name _____ Date of Birth _____
Patient's Relationship to Subscriber _____ Is this through employer? _____
Effective Date _____ Employer? _____

2nd Insurance Company Name _____
Address _____
Policy Number _____ Group Number _____ Plan _____
Subscriber's Name _____ Date of Birth _____
Patient's Relationship to Subscriber _____ Is this through employer? _____
Effective Date _____ Employer? _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

The following questions must be asked of Medicare beneficiaries for every admission, outpatient encounter, or start of care. These are specific for each encounter. Comply with any instructions that follow a particular question.

PART I:

1. Are you receiving Black Lung (BL) Benefits? YES: Date benefits began: _____ (CCYY/MM/DD) NO
   (BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL)
2. Are the services to be paid by a government program such as a research grant?
   YES: Government Program will pay primary benefits for these services. NO
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   YES: DVA is Primary for these services. NO
4. Was the illness/injury due to a work-related accident/condition? YES: Date of injury/illness:_____ (CCYY/MM/DD) NO **(GO TO PART II.)**
   Name and address of WC Plan: _____
   Name & address of employer: _____
   Policy or identification number: _____

PART II:

1. Was illness/injury due to a non-work related accident? YES: Date of accident: _____ (CCYY/MM/DD) NO **(GO TO PART III.)**
2. What type of accident caused the illness/injury? Automobile Non-automobile:
   Name & address of no-fault or liability insurer: _____
   Insurance Claim Number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

3. Was another party responsible for this accident? YES: Name & address of any liability insurer: NO **(GO TO PART III.)**
   Insurance claim number:_____

PART III:

1. Are you entitled to Medicare based on:
   Age: (GO TO PART IV.) **Disability:** (GO TO PART V.) **ESRD:** (GO TO PART VI)

PART IV - Age:

1. Are you currently employed? YES: Name & address of your employer: _____
   NE: Never employed
   NO: Date of retirement: _____ (CCYY/MM/DD)
2. Is your spouse currently employed? YES: Name & address of spouse's employer: _____
   NE: Never employed
   NO: Date or retirement _____ (CCYY/MM/DD)

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 & 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment? YES: Continue NO: STOP
4. Does the employer that sponsors your GHP employ 20 or more employees?
   YES: **STOP GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:**
   Name & address of GHP: _____ Policy ID #:_____ Group ID # _____
   Name of Policy Holder:_____
   Membership Number: _____ Effective Date: _____ Relationship of Patient: _____
   NO: **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART V - Disability:

1. Are you currently employed? YES: Name & address of employer: _____
   NE: Never employed
   NO: Date of retirement: _____ (CCYY/MM/DD)
2. If married, is your spouse employed? YES: Name & address of employer: _____
   NE: Never employed
   NO: Date of retirement: _____ (CCYY/MM/DD)

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2. Do not proceed any further.

3. Do you have a group health plan (GHP) coverage based on your own, or a family member's, current employment? YES:
   NO: **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**
4. Are you covered under the group health plan of a family member other than spouse:
   YES: Name and address of your family member's employer. _____
   NO:
5. Does the employer that sponsors your GHP employ 100 or more employees?
   YES: **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:**
   Name & address of GHP: _____ Policy ID #:_____
   Group ID #:_____
   Name of Policy Holder:_____
   Membership Number: _____ Effective Date: _____ Relationship of Patient: _____
   NO: **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART VI - ESRD:

1. Do you have group health plan (GHP) coverage?
   YES: Name & address of GHP: _____ Policy ID #:_____ Group ID #:_____
   Name of Policyholder: _____
   Membership Number: _____ Effective Date: _____ Relationship of Patient: _____
   Name & address of employer, if any, from which you receive GHP coverage: _____
   NO: **STOP. MEDICARE IS PRIMARY.**
2. Have you received a kidney transplant? YES: Date of transplant: _____ (CCYY/MM/DD) NO:
3. Have you received maintenance dialysis treatments? YES: Date dialysis began: _____ (CCYY/MM/DD) NO:
   If you participated in a self-dialysis training program, provide the date training started:_____ (CCYY/MM/DD)
4. Are you within the 30-month coordination period? YES: NO: **STOP. MEDICARE IS PRIMARY**
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? YES: **CONTINUE** NO: **STOP.**
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? YES: **STOP.** NO: **CONTINUE**
7. Does the working aged or disability MSP provision apply (i.e. is the GHP primary based on age or disability entitlement)? YES: NO: