MEDICARE SECONDARY CLAIM DEVELOPMENT (SCA)

NAME	MEDICARE HEALTH INSURANCE CLAIM NUMBER
John Q. Public	555-55-5555

PART I - INFORMATION ABOUT YOU

1) Do you have any group health plan coverage based upon your current employment?

YES ☐ **NO** ☒ (If **NO**, go to **PART II**)

2) How many employees, including yourself, work for the employer from whom you have health insurance?

1-19 ☐ **20 or More** ☐

Please print below the name of the employer and information about the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

CITY STATE ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

DATE INSURANCE COVERAGE BEGAN (M M – D D – Y Y Y Y) POLICY NUMBER

TYPE OF INSURANCE: HOSPITAL AND MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY ☐

PART II - MORE INFORMATION ABOUT YOU

1) Are you receiving Black Lung Benefits?

YES ☐ **NO** ☒ If **YES,** Date Benefits Began: (M M – D D – Y Y Y Y)

2) Are you receiving workers' compensation benefits?

YES ☐ **NO** ☒ If **YES,** Date of Illness or Injury: (M M – D D – Y Y Y Y)

3) Are you receiving treatment for an injury or illness which another party could be held liable or is covered under automobile no-fault insurance?

YES ☐ **NO** ☒ If **YES,** Date of Illness or Injury: (M M – D D – Y Y Y Y)

NAME OF INSURANCE CARRIER:

ADDRESS

ADDRESS

CITY STATE ZIP