MEDICARE SECONDARY CLAIM DEVELOPMENT (SCE)

NAME: John Q. Public

MEDICARE HEALTH INSURANCE CLAIM NUMBER: 555-55-5555

PART I - INFORMATION ABOUT YOU

1) Do you have any group health plan coverage based upon your current or former employment?
YES ☐ NO ☐ (If NO, go to PART II)

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

EMPLOYER NAME: ABC COMPANY

ADDRESS: 3 TEST DRIVE

CITY: SAMPLE STATE: OH ZIP: 211111

NAME OF HEALTH PLAN: BETTER HEALTH INC.

ADDRESS: 3 FEELING GOOD WAY

ADDRESS:

CITY: SAMPLE STATE: OH ZIP: 211111

DATE INSURANCE COVERAGE BEGAN: 04 (MM) - 15 (DD) - 2003 (YYYY)

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: __ (MM) - __ (DD) - ____ (YYYY)

2) Are you receiving workers' compensation benefits?
YES ☐ NO ☒ If YES, Date of Illness or Injury: __ (MM) - __ (DD) - ____ (YYYY)

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: 01 (MM) - 06 (DD) - 1992 (YYYY)

NAME OF INSURANCE CARRIER: AUTO INSURANCE

ADDRESS: 1 RED DRIVE

ADDRESS:

CITY: WHEELER STATE: OH ZIP: 21113

POLICY or CASE NUMBER: 9876543