

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name _____ Integrated SMPT Acct # _____

Medicare # (exactly as on Red-White-Blue Government Medicare Card) _____

Please read and respond to each of the following:

1. Have you received Home Health Care of any kind in the past 60 days? Yes or NO

If yes, please provide the name and phone number of the Home Health Agency:

Home Health Agency Name: _____

Home Health Agency Phone Number: _____

2. Was your illness/injury due to any of the following: Yes or No If yes, please indicate.

- Work-Related
- Automobile Accident
- Accident on Property (other than your own)
(Example: store, restaurant, etc.)

3. If Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer?

- Yes – the group insurance will be primary
- No – Medicare will be primary

4. Do you have any benefits through TriCare (formerly Champus)? Yes or No

If you answered yes to questions 2 or 3 there is a second form to be filled out.

Patient's Signature _____ Date _____

Thank You

MSP cont.

Patient Name _____ Integrated SMPT Acct # _____

If you answered **yes** to questions 2 or 3 on the MSP Questionnaire the following questions will need to be completed:

The group insurance will be primary

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

Employer: _____

Insured's Name: _____

Policy Identification Number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Was your illness/injury due to any of the following?

Work-Related Accident Date: _____

Automobile Accident Accident Date: _____

Accident on Property (other than your own) Accident Date: _____
(Example: store, restaurant, etc.)

Please give details of the accident: _____

Please provide the name, address and contact information of the liability insurance:

Insurance Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

Contact: _____

Claim Number: _____ (**required** for proper follow up)

Note: Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare and appreciate your cooperation.

1. Do you feel you have a right to be compensated by a party who may have caused the injury or illness?

Yes No

2. If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness?

Yes No

If yes, please provide the attorney information below:

Attorney Name: _____

Name of Law Firm: _____

Address: _____

City, State & Zip: _____

Phone: _____

Do you authorize Integrated Sports Medicine and Physical Therapy to release your medical records to the above mentioned attorney and/or law firm (including but not limited to: therapy notes and itemized statements for billing purposes) that are related to the treatment you will be receiving for your injury here at Integrated?

Yes No

Patient signature: _____ Date _____

Patient's Signature _____ **Date** _____

Thank you for your cooperation!

Revised 06/12/2006



OPTIMAL INSTRUMENT Demographic Information

1. Date of Birth _____
mm / dd / yyyy
2. Sex
 - 1) ___ Male
 - 2) ___ Female
3. Race
 - 1) ___ Aleut/Eskimo
 - 2) ___ American Indian
 - 3) ___ Asian/Pacific Islander
 - 4) ___ Black
 - 5) ___ White
 - 6) ___ Other
4. Ethnicity
 - 1) ___ Hispanic or Latino
 - 2) ___ Not Hispanic or Latino
5. Insurance (Please check all that apply)
 - 1) ___ Workers' compensation
 - 2) ___ Self-pay
 - 3) ___ HMO/PPO/private insurance
 - 4) ___ Medicare
 - 5) ___ Medicaid
 - 6) ___ Auto
 - 7) ___ Other
6. Education (Please check one)
 - 1) ___ Less than high school
 - 2) ___ Some high school
 - 3) ___ High school graduate
 - 4) ___ Attended or graduated from technical school
 - 5) ___ Attended college, did not graduate
 - 6) ___ College graduate
 - 7) ___ Completed graduate school/advanced degree
7. Please check the combined annual income of everyone in your house:
 - 1) ___ Less than \$10,000
 - 2) ___ \$10,000–\$14,999
 - 3) ___ \$15,000–\$24,999
 - 4) ___ \$25,000–\$34,999
 - 5) ___ \$35,000–\$49,999
 - 6) ___ \$50,000–\$74,999
 - 7) ___ \$75,000–\$99,999
 - 8) ___ \$100,000–\$149,999
 - 9) ___ \$150,000 or more
8. Employment/Work (Check all that apply)
 - 1) ___ Working full-time outside of home
 - 2) ___ Working part-time outside of home
 - 3) ___ Working full-time from home
 - 4) ___ Working part-time from home
 - 5) ___ Working with modification in job because of current illness/injury
 - 6) ___ Not working because of current illness/injury
 - 7) ___ Homemaker
 - 8) ___ Student
 - 9) ___ Retired
 - 10) ___ UnemployedOccupation: _____
9. Do you use a: (Check all that apply)
 - 1) ___ Cane?
 - 2) ___ Walker, rolling walker, or rollator?
 - 3) ___ Manual wheelchair?
 - 4) ___ Motorized wheelchair?
 - 5) ___ Other: _____
10. With whom do you live? (Check all that apply)
 - 1) ___ Alone
 - 2) ___ Spouse/significant other
 - 3) ___ Child/children
 - 4) ___ Other relative(s)
 - 5) ___ Group setting
 - 6) ___ Personal care attendant
 - 7) ___ Other: _____
11. Where do you live?
 - 1) ___ Private home
 - 2) ___ Private apartment
 - 3) ___ Rented room
 - 4) ___ Board and care/assisted living/group home
 - 5) ___ Homeless (with or without shelter)
 - 6) ___ Long-term care facility (nursing home)
 - 7) ___ Hospice
 - 8) ___ Other

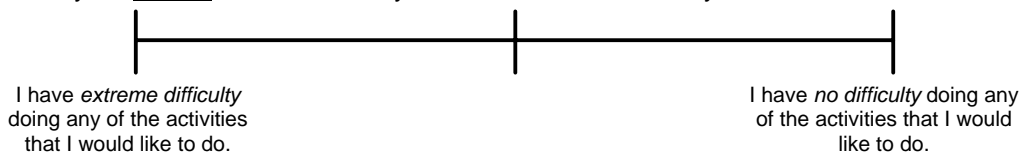
Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515–530.

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. ____ 2. ____ 3. ____

© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact permissions@apta.org or visit www.apta.org/publications.

Adapted/ revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.

