



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

Medicare Secondary Payer Reporting Questionnaire

You have filed a workers' compensation claim or liability claim against the state of Florida for bodily injuries. Also, you have been identified as a recipient of Medicare benefits. Since you are eligible for Medicare benefits, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 1862 (b) of the Social Security Act (42 U.S.C. 1395(y)(b)) requires that we report your claim to the Centers for Medicare and Medicaid Services (CMS). The copy of federal law is available at

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ173.110.pdf

The specific regulation that mandates that we collect the information on this form is available at

<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html>.

In order for us to process or settle your claim, you **must** fully complete this form and return this form in the envelope provided. **All questions must be answered. Use "N/A" if a question is not applicable to you.** If you have questions on your workers' compensation claim, call 800-262-4402; on your liability claim, call 850-413-3122.

I. Information about Injured Party:

Last Name	First Name	Initial	Social Security #**	Male ☐	Date of Birth
_____	_____	_____	___/___/___	Female ☐	___/___/___
					MM DD YYYY

II. Information about Injury/Incident/Illness:

Date of Incident	State Where Injury Occurred	Was your injury caused, or contributed to by a particular product (e.g. a defective tool, floor surface, furniture, etc.)?	Product Generic Name
___/___/___	_____	Yes ☐ No ☐	_____
MM DD YYYY			



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Product Brand Name

Product Manufacturer

Injury allegedly caused by Product

Description of Injuries

Include description of all body parts injured, (e.g. head, arm, leg, etc.), types of injuries, (e.g. strains, fractures, lacerations, etc.) and causes of injuries, (e.g. slip and fall, auto accident, lifting injury, etc.) Provide ICD-9 injury diagnosis codes if known.

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III. Information about Attorney or Representative for Injured Party:

Injured Party Representative <i>A= Attorney, G =Guardian or Conservator, P = Power of Attorney, O = Other</i>	Last Name	First Name	Firm Name
_____	_____	_____	_____

Representative's Federal Tax Identification Number (TIN) or Social Security Number**:	Mailing Address	Phone number
_____ - _____ - _____	Address: _____ City: _____ State: _____ Zip Code: _____	_____

IV. Information if Claimant is not the Injured Party or Medicare Beneficiary Identified in Section I.

Claimant's Tax Identification Number or Social Security Number** <i>Must not match injured party named in Section I.</i>	Claimant Last Name	Claimant First Name	Middle Initial	Claimant Relationship
_____ - _____ - _____	_____	_____	_____	<i>Relationship of the Claimant to the Injured Party/Medicare Beneficiary: E= Estate, F= Family, O= Other</i> _____

Claimant's Mailing Address	Claimant's Phone #
Address: _____ City: _____ State: _____ Zip Code: _____	_____

V. Information Required if Claimant (From Section IV.) has Attorney or Representative:

Claimant Representative	Rep. Last Name	Rep. First Name	Rep. Firm Name
<i>A= Attorney, G = Guardian or Conservator, P = Power of Attorney, O = Other</i> _____	_____	_____	_____

Taxpayer ID Number (TIN) _____ - _____ - _____

I certify that I have answered all the questions above and the information provided is true and correct to the best of my knowledge:

Signature _____ Printed Name: _____

Phone Number _____

Return to: Florida Department of Financial Services, Division of Risk Management, 200 East Gaines Street,
Tallahassee, Florida 32399-0338

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****Purpose and Use Statement required by Section 119.071(5), Florida Statutes**

Pursuant to the Privacy Act of 1974, 5 U.S.C. Section 552a, the State is responsible for informing you whether disclosure of your social security number is mandatory or voluntary, by what statutory or other authority your social security number is solicited, and what uses will be made of your social security number. Under section 119.071(5)(a)2., F.S., a state agency may collect your social security number if the collection is specifically authorized by law or if it is imperative for the performance of the agency's duties and responsibilities as prescribed by law.

Disclosure of your social security number on this form is: mandatory pursuant to the Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and it is imperative for the Department to perform its duties and responsibilities as prescribed by law. The social security number will be used to verify eligibility in the Federal Medicaid, Medicare and SCHIP programs in order to determine if any liens are levied against a potential recovery, and as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law. Your social security number is confidential and exempt from the disclosure requirements of section 119.07(1), F.S., and section 24(a), Article I of the Florida Constitution and will not be used for any purpose other than the purpose(s) provided herein, or as otherwise authorized under section 119.071(5)(a), F.S.

A copy of this Privacy Statement is provided to you as required by section 119.071(5)(a)3., F.S.