ACCIDENT QUESTIONNAIRE

Date_____

Injured Party_____

Member ID Number_____

Date of Occurrence_____

Dear _____:
(Patient)

In order to update our records and complete claims processing we are asking that you complete this questionnaire concerning your injuries.

Thank you for assisting our efforts in providing quality service.

Briefly describe the cause of injury: (e.g., location of accident/how it happened)

_____

Name of other Insurance Company (e.g., auto, homeowners, workers comp)

_____

Insurance Company Address_____
(Street) (City) (State) (Zip)

Policy Holder Name_____ Policy # _____Claim # _____

If you have retained an attorney, please provide the following information:

Attorney Name_____

Address_____
(Street) (City) (State) (Zip)

Phone Number (_____)_____

Identity of other parties who may be responsible for the injuries:

Name_____ Phone Number (____) _____

Address_____

Name of Insurance Company_____ Phone Number (____) _____

Insurance Company Address_____
(Street) (City) (State) (Zip)

Policyholder Name_____ Policy Number_____

Adjuster Name_____ Claim Number_____

Date_____ Member Signature_____