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)

Telephone Number: (_____) _____

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

Name: _____ Telephone Number: (_____) _____

Address: _____
(Street) (City) (State) (Zip)

Name of Insurance Company: _____ Telephone Number: (_____) _____

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Policyholder Name: _____ Policy Number: _____

Adjuster Name: _____ Claim Number: _____

Member Signature: _____ Date: _____