

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 _____