



Claims/Injury Questionnaire

MEMBER NAME: _____ MEMBER ID#: _____

PATIENT NAME: _____ PATIENT ID#: _____

EMPLOYER: _____ GROUP#: _____

DATE OF SERVICE: _____ CLAIM#: _____

Dear Patient:

Please complete this form and return within one week to avoid delay and/or denial of the referenced claim.

If the claim was not due to an accident or work related illness (i.e.: carpal tunnel), please check the space and return form. _____

If the claim is the result of an accident/work-related illness, please provide the following information.

1. Is the accident ? work related ? automobile related ? other, please explain:

2. **What was the date of the injury?** _____

3. How and where did the injury occur?
(Please give a brief description.) _____

4. **Please list the names of all family members involved in the accident:**

5a. **Is there another insurance company involved in payment of the claim (s)?** _____

b. If yes, please provide the name and address of the other insurance company and the policy holder of this insurance:

Other insurance carrier
name: _____

Adjuster's name: _____

Address and telephone number: _____

Claim number: _____

Policy holder name: _____ Policy number: _____

6. **Is the patient represented by an attorney?** Yes No If yes, please provide the attorney's name, address, and telephone number.

Member Signature

Date