



ACCIDENT QUESTIONNAIRE

Subscriber: _____
Address: _____
Address: _____

Patient: _____
Identification No.: _____
Provider: _____
Date of Service: _____
Group Number: _____
Claim Number: _____
Claim Amount: _____

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information, we may have to deny your claims. **If you have previously completed a form for this accident, please check here ___ and update.**

Was the injury or illness: **Auto/Motorcycle Accident** _____ **Work Related** _____ **Other Accident** _____ **No Accident** _____

Date of the injury or illness: _____ City/County and State of Injury: _____

Describe the injury or illness and how it happened: _____

Names of other family members injured: _____

If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:

Did another person cause this accident? YES / NO

If yes, name and address of person causing injury: _____

Insurance Company of person causing injury: _____ Policy/Claim #: _____

Address and Phone #: _____ Adjuster's Name: _____

If auto or motorcycle related, was the patient wearing a seatbelt? YES / NO a helmet? YES / NO

If auto or motorcycle related, was the patient the driver _____ or a passenger _____ ?

Auto Insurance Company of Patient: _____ Policy/Claim #: _____

Address and Phone #: _____ Adjuster's Name: _____

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: _____

Have you filed a Workers' Compensation claim? YES / NO

If yes, name of Workers' Compensation carrier: _____

Policy/Claim #: _____ Adjuster's Name: _____

Address and Phone #: _____

Has the employer or the workers' compensation carrier accepted or denied liability? ACCEPTED / DENIED

Name, address, and telephone number of your attorney (if applicable): _____

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation / Workers' Compensation Department of InStil Health Insurance Company.

Signature

Date

Telephone Number