

# 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 \_\_\_\_\_  
(Street) (City) (State) (Zip)

Name of Insurance Company \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Insurance Company Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Policyholder Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Member Signature \_\_\_\_\_ Date \_\_\_\_\_