SUPPLEMENTAL ACCIDENT QUESTIONNAIRE

Employer: _____ Group Number: _____

Employee: _____ Soc. Sec. No.: _____

Patient Name: _____ Date of Service: _____

Please answer all of the following questions in detail.
Failure to provide complete information may delay the processing of your claims.

Is this claim the result of an accidental injury? ☐ Yes ☐ No

Is this claim the result of a motor vehicle/recreational vehicle accident? ☐ Yes ☐ No

If YES to either of the above questions, please continue:

1. Date of accident _____/_____/_____

   Location (Address):

   _____

   _____

   Briefly explain how this injury occurred:

   _____

   _____

   _____

2. Is this a work related injury? ☐ Yes ☐ No (Employee / Spouse Only)

3. Is this injury due to a school function or participation on an organized sports team? ☐ Yes ☐ No

4. Do you intend to make a claim against another party for this claim? ☐ Yes ☐ No

5. Please list the name and address of any other responsible party, property owner or insurance company:

   Name Address

   _____

   _____

   _____

SIGNATURE: _____ DATE: _____

Warning: Any person who knowingly and with intent to defraud any insurance company or plan, files a statement of claim containing any materially false information or conceals information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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