

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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