

# SUPPLEMENTAL ACCIDENT QUESTIONNAIRE



Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Member ID.: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_

**Please answer 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.

**FAX (717) 581-8379**