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Med-Pay, Inc.

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ACCIDENT/INCIDENT QUESTIONNAIRE

Insured: ID#: Claim#:

Patient: Group:

If additional space is required to complete the questions below, please attach a separate paper. Thank you.

1. Confirm accident date and location:

2. Provide a detailed description of the incident, including how it happened. Be sure to identify if another party may be liable/at fault:

3. For each person, please specify which body part(s)/area(s) were injured:

4. Other contributing factors. Please complete applicable response(s), including explanations, as applicable.
   Was injury work-related? Yes___ No___ If yes, please explain on reverse side.
   Was injury alcohol-related? Yes___ No___ If yes, please explain on reverse side.
   Was injury due to poisoning, including drugs? Yes___ No___ If yes, please explain on reverse side.
   Was injury due to an act of violence? Yes___ No___ If yes, please explain on reverse side.
   Was injury due to a faulty product/malpractice? Yes___ No___ If yes, please explain on reverse side.
5. Attach a copy of the police report, if available; and provide any other information that will assist in the processing of the claims on the reverse side:
6. If this was an auto accident, complete the following applicable response(s) from the following options:
   Driver: _____ Passenger(s): _____
   Was any of the injured family members a pedestrian? Yes___ No___ If yes, who?
   Was another vehicle/entity involved? Yes___ No___ If yes, items 10 through 13 must be completed.
7. Did you file a claim with insured's / patient's auto insurance (or homeowners company) and/or any other legal action relating to this accident? Yes___ No___ If yes, claim number:
8. Name, address, phone number, and policy number of Insured's / Patient's auto or other insurance carrier, even if the answer to #7 is 'NO':
9. Insured's / Patient's attorney name and address, if any:

PLEASE COMPLETE THE FOLLOWING FOR ACCIDENTS THAT INVOLVE ANOTHER PARTY:

10. Name and address of any Other Party involved:
11. Name, address, phone number, and claim number (if known) of Other Party's insurance carrier, including auto, homeowners, or other:
12. Other Party's attorney name and address, if known:
13. If you have not yet filed a claim or suit, do you intend to do so? Yes___ No___ Undecided___

With my signature below, I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to the denial of the claims related to this incident/accident.

Patient/Insured Signature (or that of an authorized representative) _____ Date

Printed Name _____ Relationship to Patient/Insured

☐ **Check this box if you are appealing claims that have been denied for receipt of this information.**