

## 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 failure to provide this information.