PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

# ACCIDENT CLAIM QUESTIONNAIRE

**PATIENT NAME:** _____ **INSURED EMPLOYEE NAME:** _____

**INSURED'S ID** _____ **PATIENT'S BIRTH DATE:** _____

**EMPLOYER GROUP:** _____ **EMPLOYER GROUP NUMBER:** _____

**CLAIM ID:** _____

## OTHER INSURANCE INFORMATION

Do you, your spouse or child have any other medical insurance? ☐ Yes ☐ No

Name of Policy Holder _____

Other insurance company _____ Policy Number _____

Address: _____ Phone: _____

## TYPE OF INJURY

Was treatment due to: (check below)

☐ Illness/Condition (No accident/injury)
☐ Injury at home
☐ Injury occurring on someone else's property
☐ Motor vehicle Accident/Injury/Condition
☐ Work-related Accident/Injury/Condition
☐ Military/Service related Accident/Injury/Condition

## INJURY DETAILS

Please provide complete details for the following questions:

1. When did the accident/injury occur? _____
2. Where did the accident/injury occur? _____
3. How did the accident/injury occur? *(Please use the back of this form if you need more space)*

   _____

   _____

   _____
4. If work related, has your claim been accepted by your employer's workers' compensation carrier? ☐ Yes ☐ No
   *- If no, please attach the Notice of Controversy*
5. If related to an automobile, motorcycle, snowmobile, or all terrain vehicle accident, do you have a private insurance policy which covers personal injury claims? ☐ Yes ☐ No
   If yes, please advise the company name, address and policy number of this policy.

   _____

   _____
6. Was a police report filed? ☐ Yes ☐ No *- If yes, please attach a copy of this report.*
7. Is another party responsible/liable for this accident? ☐ Yes ☐ No
   If yes, please advise the name and address of the other party.

   _____

   _____
8. Did the accident/injury occur on someone else's property? ☐ Yes ☐ No
   If yes, has a claim been filed with their homeowner's insurance company? ☐ Yes ☐ No
9. Have you retained an attorney? ☐ Yes ☐ No
   If yes, please complete the following:

   Attorney Name: _____

   Firm Name and address: _____

   Telephone Number: _____

**I hereby certify that I have carefully read the contents of the above report and that the information therein is**

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**true and accurate to the best of my knowledge.**

Authorized Signature:_____ Date: _____

Patient's Signature:_____ Date: _____
*(Parent or Legal Guardian must sign if patient is a minor)*

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**MAIL TO: PATIENT ADVOCATES, LLC ■ P.O. BOX 1959 ■ GRAY, ME 04039**