P.O. Box 2602
Fort Wayne, IN 46801
Phone: 888-312-9744
Fax: 260-479-3545

INJURY QUESTIONNAIRE – RETURN TO ADDRESS NOTED ABOVE

Group # ____________ Group Name ____

Employee Name ______________________________ Member ID ________________

Patient Name ________________________________ Relationship ________________

Claim # _____________________________________

1. The diagnosis listed on your claim indicates treatment may be due to an injury.

   Please provide the details of the injury/accident (how did it occur):
   ____
   ____
   ____

   Date of injury/accident:____

   Did the injury/accident occur at Home_____ Work_____ Other______________

   Accident Address____
   Was a police report filed? Yes_____ No_____

   If yes, please provide a copy of the police report.

2. Is this claim the result of any injury or accident that involved any other party? Yes_____ No_____

   A. If yes, have you filed a claim with the liable party's insurance company or attorney?
   Yes_____ No_____

   B. Please provide the name, address, and telephone number of the party.__________________________
   ____

   C. Please provide any case #'s, reference #'s, or claim #'s____________________________________

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Claim # _____________________________________

3. If the accident was the result of occupying/using any type of motor vehicle please provide the following:

Your Auto Insurance Carrier Name ____
Your Auto Insurance Carrier Address ____
Your Auto Insurance Phone Number ____
Your Auto Insurance Policy Number ____
Policyholder Name/Names ____
Your Auto Insurance Claim Number ____
Third Party Insurance Carrier Name ____
Third Party Insurance Carrier Address ____
Third Party Insurance Phone Number ____
Third Party Insurance Policy Number ____
Third Party Name/Names ____
Third Party Insurance Claim Number ____

4. Will you be retaining an attorney? Yes_____ No_____

If yes, please provide attorney's name, address, and phone number.

Name ____
Address ____
Phone Number ____________________________________
Case Number _____________________________________

I, the undersigned, hereby grant my permission for release of medical and payment information relating to my insurance coverage(s) to MedPartners Administrative Services, Inc, or to it's appointed representatives. The purpose of this release is to allow my Health Care Plan to appropriately administer benefits. This authorization specifically pertains to information related to above signed participant's claims.

By typing, signing my name below, I hereby certify that the information I have given is true and accurate.
I understand that the medical plan has a Subrogation/Reimbursement provision that states:
Medical benefits paid under the plan are to be reimbursed from the payments, awards, settlements that may be due from any third party. I, therefore agree to make reimbursement to the plan from any third party payments that have been received by me.

____ ___________________________
Participant's Signature Date