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

Updated 2016