AULTCARE

Group Number:_____
Member ID:_____
Member Name:_____
Patient Name:_____

INJURY/ACCIDENT QUESTIONNAIRE

All claims related to this injury/accident questionnaire will be **PENDED/DENIED** until this fully completed questionnaire is returned. If you have any questions, please contact Customer Service at the number listed below.

1.) What was the date of your injury/accident?_____

2.) How did your injury/accident occur?_____
_____
_____

3.) Where did the injury/accident occur? (Please select the appropriate box.)
☐ Auto/Motorized Vehicle
☐ Home
☐ Work (If yes, was a workers' comp claim filed?) ☐ YES ☐NO
☐ There was no accident, sudden onset (Please contact Customer Service)
☐ Other, please specify_____

4.) Automobile Accident Information
   a. If an automobile accident, were you a driver, a passenger or a pedestrian?_____
      _____
   b. If auto accident, were all the covered family members involved wearing seatbelts at the time of the accident?_____
   c. If accident involved a motorcycle or recreational vehicle, was a helmet being worn at the time of the accident?_____
   d. If motor vehicle accident, were you or a covered family member under the influence of drugs or alcohol? (Includes all motorized recreational vehicles, boats,etc.)?
      _____
   e. Is there a police report? ☐ YES ☐ NO
      If yes, where can we obtain a copy?_____
   f. Were any parties in the accident charged? Who? What offense?_____
      _____
      _____

PO Box 6910 | Canton, OH 44706
Phone: 330-363-6360 |-800-344-8858
TTY: 711
Website: www.aultcare.com

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5.) What is the name, address, and telephone number of other insurance carriers that a claim has been filed with? What is the claim number and the adjuster's name?_____
_____
_____

6.) Were you responsible for the accident? ☐ YES ☐ NO

7.) Was another party responsible for your accident? ☐ YES ☐NO
If no, please sign and return the form. Do not complete questions 8-10.

8.) a.) What is the name, address, and telephone number of the party responsible for your accident?_____
_____
_____

b.) What is the name, address, and telephone number of the other party's insurance carrier? Claim number and adjuster's name?_____
_____
_____

9.) Have any payments been made for expenses incurred as a result of this accident?
☐ YES ☐ NO
If yes, please explain._____
_____

10.) Have you retained an attorney? ☐ YES ☐ NO
If yes, what is the name, address, and telephone number of your attorney?_____
_____
_____

I hereby authorize that the plan administrator is entitled to recover claim payments made on my behalf, from any future settlement in my favor, from the third party of other insurance carriers responsible for my accident and corresponding claim(s) outlined above. Recovery can also be made from me if I receive the settlement directly from the third party or other insurance carrier.

I hereby authorize the plan administrator to forward copies of claims to the insuring company and attorney.

I hereby authorize release of any information necessary to verify or investigate items pertaining to this accident.

_____ _____
Signature Date

_____
Relationship to the patient