



ACCIDENT/ILLNESS QUESTIONNAIRE

Please check the appropriate box below, complete forms as instructed, and return this questionnaire to Compass Health Administrators.
 The accident/illness IS due to fault of another party. Please complete entire questionnaire and the attached reimbursement agreement.
 The accident/illness IS NOT due to the fault of another party. Please only complete Sections 1 -3.

SECTION I – PATIENT INFORMATION

1. Patient Name:	2. Patient Date of Birth:	3. Patient ID #:
4. Patient Address (Street/City/State/ Zip):	5. Patient Phone:	6. Alternate Phone:
7. Parent/Guardian Name (If Patient under 18 yrs of age): <input type="checkbox"/> N/A	8. Subscriber Name: <input type="checkbox"/> Same as Patient	9. Patient Relation to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other: _____

SECTION II – GENERAL INFORMATION

10. Date of Accident, Injury or Onset of Illness:	11. Please check one: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident/Injury <input type="checkbox"/> Illness
12. Briefly describe how accident/injury occurred.	
13. Where did the accident occur?	
14. Who was at fault in the accident/injury?	
15. What were your injuries?	
16. Were you wearing any required safety equipment such as seatbelt or helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION III – CLAIMS INFORMATION

<p>17. Did you or will you be filing a claim with:</p> <p><input type="checkbox"/> Auto policy (including you own)</p> <p><input type="checkbox"/> Homeowner policy (including your own)</p> <p><input type="checkbox"/> Business</p> <p><input type="checkbox"/> Person(s)</p>	<p>If you have or will be filing a claim please identify who the claim or action is against and insurance company, business, or person(s) below:</p> <p>Name (of policyholder if applicable): _____</p> <p>Insurance Company, Business, or Person(s): _____</p> <p>Address: _____</p> <p>Phone Number: _____</p> <p>Claim or Policy Number: _____</p>
<p>18. Do you have any medical pay coverage on your own auto or homeowners policy?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (if YES, provide the carriers name, address, phone number, and your policy number)</p> <p>Carrier Name: _____</p> <p>Address: _____</p> <p>Phone Number: _____</p> <p>Policy Number: _____</p>



ACCIDENT/ILLNESS QUESTIONNAIRE

HEALTH CARE ID: _____

SECTION IV – LEGAL INFORMATION

19. Have you contacted an attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If YES , provide the attorney’s name, address, and phone number below). Attorney Name: _____ Address: _____ Phone Number: _____
20. If a lawsuit has been filed, briefly describe the status of the case. (If your case has been settled, provide details and a copy of any settlement amount or judgment award.)	

SECTION V – WORK RELATED ACCIDENT/INJURY

21. Is the accident/injury work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If checked skip Question 22) If Yes , please identify below if when the accident/injury occurred you were: <input type="checkbox"/> at work <input type="checkbox"/> travelling for work <input type="checkbox"/> at a required work-sponsored event
22. Have you filed a Worker’s Compensation Claim:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete the information below: Claim/Appeal #: _____ Status of Claim/Appeal: <input type="checkbox"/> Open <input type="checkbox"/> Closed Name of Work Comp Carrier: _____ Address: _____ Phone Number: _____

I, _____, DO CERTIFY BY MY SIGNATURE THAT THE INFORMATION SUBMITTED ON THIS QUESTIONNAIRE IS TRUE AND CORRECT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION RELATING TO THIS INCIDENT TO, AND BY, MY PLAN ADMINISTRATOR, CLAIMS ADMINISTRATOR AND THE PHIA GROUP.

Signature

Date

Print Name

Primary Telephone Number

Print Name

Alternate Telephone Number