

Accident/Illness Questionnaire

Claim #:

Healthcare ID #:

Patient:

Relationship:

Service Dates:

Accident Dates:

Provider:

Dear Participant:

Delta Health Systems has partnered with the Phia Group to collect details regarding the above referenced claim. We ensure that no other entity is responsible for payment of your claims, pursue reimbursement on your plan's behalf when someone else is responsible, and return the funds to your plan in an effort to control healthcare costs. Please **complete** and **return** the enclosed materials to the address shown below:

- Questionnaire

IMPORTANT: Failure to return the signed Questionnaire may result in denial of related charges.

Your assistance in this matter is appreciated. If you have any questions, please call the number shown below, we would be happy to assist you.

Thank you,
Claims Department
Delta Health Systems



Claim#:

Healthcare ID #:

Questionnaire

If this accident/illness is due to any fault of another party please complete and return this form. If this accident/illness is NOT due to the fault of another party please only complete questions 1 – 9.

1. Patient Name	
2. Relationship to Participant	
3. Date of Accident, Injury or Onset of Illness	
4. If due to an accident/injury, please provide details of how the accident/injury occurred.	
5. Where did the accident, injury or onset of illness occur? (place/location/street)	
6. Who was at fault in the accident/injury?	
7. What were your injuries?	

Legal/Claims Information	
8. Did you, or are you going to, file a claim against any: <input type="checkbox"/> Auto policy, including your own? <input type="checkbox"/> Homeowner policy, including your own? <input type="checkbox"/> Business <input type="checkbox"/> Person(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please indicate who the claim or action is against (name of policy holder, if applicable). <hr/> Name, address and phone number of the insurance company, business or person(s): <hr/> Claim or policy number
9. Do you have any medical pay coverage on your own auto or homeowners policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please provide the carrier's name, address, phone number and your policy number.
10. Have you contacted an attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please provide your attorney(s) name, address and phone number.
11. If a lawsuit has been filed, what is the status of the case?	
<i>If your case has settled, please provide details and a copy of any settlement amount or judgment award.</i>	



Work-Related Questions	
12. At the time of the accident or onset of illness, were you: <ul style="list-style-type: none"> ▪ at work, ▪ traveling for work, or ▪ at a required work-sponsored event? 	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you filed a Workers Compensation Claim?
	If yes, please provide: Claim/Appeal #: Status: <input type="checkbox"/> Open <input type="checkbox"/> Closed
	What is the name, address and phone number of the workers comp carrier?

Accident-Related Questions	
13. Were you wearing any required safety equipment, such as a seatbelt or helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
14. Was a motor vehicle involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please include a police report with the TPL letter.

I hereby acknowledge and agree to the terms of my plan's subrogation, reimbursement and/or third party recovery provision(s). 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	_____ E-Mail
_____ Print Name	_____ Primary Telephone	_____ Alternate Telephone

