

**ACCIDENT DETAILS
MEDICAL CLAIMS REIMBURSEMENT QUESTIONNAIRE**

Patient Name: _____

Date: _____

WAS YOUR MEDICAL TREATMENT THE RESULT OF AN ACCIDENT OR INJURY?

NO _____ **YES** _____ IF YES, DATE OF INJURY _____

Pain Scale (1 to 10, 1 being least amount of pain) _____

Aggravating Factors _____ **Alleviating Factors** _____

Was the accident or injury: Motor Vehicle _____ Work Related _____

Crime Victim _____ Other _____

Details of the accident or injury _____

COMPLETE THIS SECTION IF THIS WAS CRIME RELATED

Attorney General _____ Phone Number () _____ State _____

COMPLETE THIS SECTION IF THERE WAS AN AUTO ACCIDENT

1) Patient was Driver _____ Passenger _____ Pedestrian _____

2) My Auto Insurance Company is _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

3) Have you filed a claim? Yes _____ No _____ IF YES, Claim Number _____

Name of Adjuster _____ Phone # () _____

Medpay Coverage? Yes _____ No _____ Unknown _____

4) Complete this section if Another Party is Responsible in this auto accident.

Their Name _____ Phone # () _____

Address _____ City _____ State _____ Zip _____

Their Insurance Company _____

Address _____ City _____ State _____ Zip _____

5) Have you filed a claim? Yes _____ No _____ IF YES, Claim Number _____

Name of Adjuster _____ Phone # () _____

**COMPLETE THIS SECTION IF YOU WERE ON THE JOB WHEN THE INJURY
OCCURRED OR IT IS RELATED TO YOUR EMPLOYMENT**

1) Employer's Name _____

2) Phone # () _____ Did you file a report of injury? YES _____ NO _____

3) If yes Name of Workers Compensation Carrier _____

COMPLETE THIS SECTION IF ANOTHER PARTY IS RESPONSIBLE FOR THIS

1) Property Owner's Insurance Company _____

Address _____ City _____ State _____ Zip _____

2) Have you filed a claim with their insurance company? YES _____ NO _____

3) Is an Attorney representing you on this injury? YES _____ NO _____

Attorney Name _____ Phone # () _____

Address _____ City _____ State _____ Zip _____

THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

Patient signature (OR Legal Guardian)

Phone # Home() _____

Date

Work #() _____