17 Technology Circle, Suite E2AG
Columbia, SC 29203-9591
1-800-768-4375
Fax: 1-803-870-8012

We make Benefits Better.

PATIENT: _____
ID NUMBER: _____
DATE OF SERVICE: _____
GROUP NUMBER: _____
CLAIM NUMBER: _____

ACCIDENT QUESTIONNAIRE

TIME SENSITIVE MATERIAL (Reply Immediately)

Dear Member:

Your health plan requires an Accident Questionnaire to make sure we provide proper benefits for members who may have received medical services related to an accident. To process your claims timely and accurately, we need information concerning your doctor's visit to determine if someone else is responsible for your injury or illness.

FAILURE TO PROVIDE THIS INFORMATION WITHIN 180 DAYS MAY RESULT IN CLAIM DENIALS

You can provide the information by:

- Calling 1-800-768-4375, between 8:30 a.m. and 5 p.m. ET Monday through Friday
- Completing the questions below and mail to: Planned Administrators, Inc. P.O. Box 6927, Columbia, SC 29260
- Completing the questions below and fax to: 1-803-870-8012

We thank you for your assistance and for allowing us to serve you.

Was the injury or illness:

- ☐ **Motor Vehicle Accident**
- ☐ **Work Related Accident**
- ☐ **Other Accident**
- ☐ **Assault**
- ☐ **No Accident**

Date of the injury or illness: _____

Where the accident or injury occurred (such as home, school, store, restaurant, etc.): _____

Briefly explain why you received treatment from this doctor and include body area(s) affected by this injury or illness:

If you answered **NO ACCIDENT**, please sign below and return.

If you answered **MOTOR VEHICLE ACCIDENT**, **WORK RELATED ACCIDENT**, **OTHER ACCIDENT**, or **ASSAULT**, please answer the questions on the next page (use additional page if necessary), then sign and return.

Signature: _____ Daytime Phone Number: (_____) _____

Date: _____ Evening Phone Number: (_____) _____

We must receive your response within 180 days from the date of this letter. Failure to respond in this time period may result in permanent claim denials, and you may be responsible for paying the provider directly for the full charge amount.

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If you checked "Motor Vehicle Accident," please answer the following: (Please provide a copy of the police report.)
City and state of accident: _____
Was the motor vehicle: Auto ☐ Motorcycle ☐ ATV ☐ Other ☐ (Specify:) _____
Was the patient: Driver ☐ Passenger ☐ Pedestrian ☐
Did another person cause this accident? Yes ☐ No ☐
If yes, name and address of person causing injury: _____
_____
Insurance company of person causing injury: _____ Policy/Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Was the patient wearing a seatbelt? Yes ☐ No ☐ a helmet? Yes ☐ No ☐
Auto insurance company of **patient**: _____ Policy/Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Name(s) of other family members injured in this accident: _____

If you checked "Work Related," please answer the following:
Name and address of patient's employer at time of injury: _____
_____
Name of workers' compensation carrier: _____ Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Have you filed a workers' compensation claim? Yes ☐ No ☐
Do you intend to file a workers' compensation claim? Yes ☐ No ☐
Has the employer or the workers' compensation carrier accepted or denied liability? Accepted ☐ Denied ☐
If denied, do you intend to file an appeal to the denial? Yes ☐ No ☐

If you checked "Other Accident," please answer the following:
Is someone else responsible for your injury or illness? Yes ☐ No ☐
If yes, name and address of the responsible person: _____
_____
Did the accident occur on someone else's property? Yes ☐ No ☐
Does the person have insurance to cover your medical expenses? Yes ☐ No ☐
If yes, insurance company of the responsible person: _____ Policy/Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Do you intend to file a claim against the responsible person or insurance company? Yes ☐ No ☐

If you checked "Assault," please answer the following: (Please provide a copy of the police report.)
Name and address of the responsible person: _____
_____
Name of law enforcement agency investigating the assault: _____ Case #: _____
Address: _____ Phone: (____) _____ Officer's Name: _____

Attorney Information:
Have you hired an attorney to assist you with this case? Yes ☐ No ☐
If yes, name, address, and telephone number of your attorney: _____
_____

Signature: _____ Daytime Phone Number: (_____) _____
Date: _____ Evening Phone Number: (_____) _____

We must receive your response within 180 days from the date of this letter. Failure to respond in this time period may result in permanent claim denials, and you may be responsible for paying the provider directly for the full charge amount.