Questionnaire

Member Name: 
HPHC ID: 
Date of Service: 

Was the injury/illness related to: 

- [ ] Auto/Motorcycle Accident 
- [ ] Work/Industrial Accident 
- [ ] Other (slip & fall) Accident 
- [ ] No Accident 

If this is Auto/Motorcycle related fill out Sections 1, 2 and 4. If this is Workers' Compensation related, fill out Sections 1, 3 and 4.

If this accident was NOT Auto/Motorcycle or Workers' Compensation related, but there is another party that was liable, fill out Sections 1, 2 and 4.

IF THERE IS NO OTHER PARTY LIABLE FOR YOUR INJURY, CHECK No Accident AND FILL OUT SECTION 1.

Section 1: 
Date of injury/illness: ___________________ City/County and State of injury: ____________________
Provide a brief description of how and where accident/injury occurred. 
________________________________________________________________________________________
________________________________________________________________________________________
Briefly describe the injuries that incurred as a result of the accident/injury: 
________________________________________________________________________________________
________________________________________________________________________________________
Are you still being treated for this injury?  Yes / No  If No, when did treatment stop? __________________

Section 2: 
If you checked “Auto/Motorcycle Accident” or “Other Accident,” please answer the following: 
Was the member a Pedestrian, Passenger or Driver: (circle one if applicable) 
Was the vehicle an off-road vehicle or motorcycle: (circle one if applicable) 
(please attach operator/police/incident report): 

Please list insurance information of the vehicle occupied by the member or your own auto insurance information if the occupied vehicle was uninsured: 

Owner: ___________________________________ Driver: _______________________________________
Insurance Carrier: ___________________________________________________________________________
Insurance Address: __________________________________________________________________________ 
Policy/Claim # ____________________________ Adjuster Name/Phone #: ____________________________
Medical Payment Coverage Yes / No If Yes, amount $_______________________
Name of other family members injured: __________________________________________________________
PLEASE ATTACH A COPY OF THE MEMBER’S MOTOR VEHICLE COVERAGE SELECTION PAGE

Did another person cause this injury/illness? Yes / No If Yes, fill in the person’s information below:

Owner: ___________________________________ Address: ___________________________________________

Driver (If Applicable):_______________________ Address: ______________________________________

__________________________________________________________________________________________

Insurrance Carrier: __________________________ Insurance Address: ______________________________

Adjuster Name/Phone #: _____________________ Policy/Claim #:_________________________________

Does the member intend to make a claim against the other party or their carrier for injuries? Yes / No

Section 3:
If you checked “Work/Industrial Accident,” please answer the following: (please attach operator/police/incident report):

Employer Name: ____________________________________________________________________________

Employer Address: __________________________________________________________________________

Have you filed a Workers’ Compensation claim? Yes / No
If Yes, name of Workers’ Compensation carrier:___________________________________________________

Workers’ Compensation Address: ______________________________________________________________

Policy/Claim #:______________________ Adjuster’s Name/Phone #: _______________________________

Has the Employer or Workers’ Compensation carrier accepted or denied liability? Accepted / Denied

Section 4:
Is the member represented by an attorney? Yes / No

Attorney Name: ____________________________________________________________________________

Firm Name:________________________________________________________________________________

Attorney Address:___________________________________________________________________________

Attorney Phone:_____________________________________________________________________________

I authorize Harvard Pilgrim Health Care to correspond with the above insurance company/attorney to receive information regarding claims and healthcare related issues for the above accident. I agree that the above information is correct, and I will not settle a claim before contacting the Insurance Liability Recovery Department at Harvard Pilgrim Health Care 1-888-888-4742, Extension 38999.

Member's Signature:_______________________________________ Date:_______________________

Return form to Harvard Pilgrim Health Care, P.O. Box 699187, Quincy, MA 02269.

Thank you.
Insurance Liability Recovery
Harvard Pilgrim Health Care