Harvard Pilgrim Health Care

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' Compentation 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: _____
_____
Insurance 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