AULTCARE

INJURY/ACCIDENT QUESTIONNAIRE

Group Number	Member ID
Member Name	Patient Name

All claims related to this injury/accident questionnaire will be **DENIED** until this questionnaire is fully completed and returned. If you have any questions, please contact AultCare at 330-363-6360 or 1-800-344-8858 (TTY: 711).

1. What was the date of your injury/accident?

2. How did your injury/accident occur? _____

_____

3. Where did the injury/accident occur? (Please select the appropriate box.)

☐ Auto/motorized vehicle

☐ Home

☐ Work (If yes, was a workers' compensation claim filed?) ☐ Yes ☐ No

☐ There was no accident, sudden onset (Please contact AultCare)

☐ Other, please specify _____

4. Automobile Accident Information

a. If an automobile accident, were you ☐ a driver, ☐ a passenger, ☐ a pedestrian?

b. If this was an auto accident, were all the covered family members involved wearing seatbelts at the time of the accident? ☐ Yes ☐ No

c. If accident involved a motorcycle or recreational vehicle, was a helmet worn at the time of the accident? ☐ Yes ☐ No

d. If this was a motor vehicle accident, were you or a covered family member under the influence of drugs or alcohol? (Includes all motorized recreational vehicles, boats, etc.) ☐ Yes ☐ No

e. Is there a police report? ☐ Yes ☐ No

If yes, where can we obtain a copy? _____

f. Were any parties in the accident charged? ☐ Yes ☐ No

Who? _____

What offense? _____

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5. Other insurance carrier information where a claim has been filed

Insurance name

Address

Phone number	Claim number	Adjuster name

6. Were you responsible for the accident? ☐ Yes ☐ No

If yes, please sign and return the form. Do not complete questions 8-10.

7. a. Information on party responsible for accident

Name

Address	Phone number

b. Information on other party's insurance carrier

Insurance name

Address

Phone number	Claim number	Adjuster name

8. Have any payments been made for expenses incurred as a result of this accident? ☐ Yes ☐ No

If yes, please explain. _____

_____

9. Have you retained an attorney? ☐ Yes ☐ No

If yes, please provide your attorney's information.

Name

Address	Phone number

INSURANCE FRAUD WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I acknowledge that AultCare may use and disclose my protected health information, as well as, the protected health information of my family for payment, treatment, and operations. This information may be disclosed to other insurance companies, third party administrators, state and federal agencies, health care providers and other organizations and persons that perform professional, business, or insurance functions for AultCare, as permitted by state and federal law. The information may be used for, but not limited to, processing enrollment applications, risk classifications, detecting or preventing fraud, internal and external audits, claims administration, case management, quality improvement programs, public health reporting, law enforcement investigations, coordination of benefits, medical management programs, and subrogation.

I hereby authorize the plan administrator is entitled to recover claim payments made on my behalf, from any future settlement in my favor, from the third party of other insurance carriers responsible for my accident and corresponding claim(s) outlined above. Recovery can also be made from me if I receive the settlement directly from the third party or other insurance carrier.

I hereby authorize the plan administrator to forward copies of claims to the insuring company and attorney.

I hereby authorize release of any information necessary to verify or investigate items pertaining to this accident.

Signature _____ Date _____

Relationship to the patient _____