INTEGRITY HOME CARE + HOSPICE GROUP HEALTH PLAN ACCIDENT QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AND RETURN TO: **MERCY BENEFIT ADMINISTRATORS**
PO BOX 14230
SPRINGFIELD, MO 65814

MEMBER NAME: _____ MEMBER ID #: _____CLAIMANT NAME: _____

DATE OF SERVICE: _____
(FOR YOUR REFERENCE, THIS INFORMATION IS AT THE TOP OF THE ACCOMPANYING LETTER)

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE REGARDING THE CLAIM LISTED ON THE ACCOMPANYING LETTER. ONCE THIS INFORMATION IS RECEIVED, WE WILL BE ABLE TO CONTINUE PROCESSING YOUR CLAIMS.

1. Was the above date of service related to an ACCIDENT/INJURY?: _____

   a. If NO, please describe why services were sought on the above date of service, sign and date on back and return:_____

   _____

   b. If YES, please complete the remaining questions.

2. Date of ACCIDENT/INJURY(if different from above date of service) :_____

3. Location of ACCIDENT/INJURY including address, city, county, and state: _____

   _____

4. Please provide details of how ACCIDENT/INJURY occurred:_____

   _____

   _____

   _____

5. Did the ACCIDENT/INJURY arise out of or in the course of your employment, if applicable? _____

   If yes, provide name, address, city and state of employer: _____

   _____

6. List witnesses and any contact information known or available to you: _____

   _____

7. Was a police/law enforcement or incident report made? YES____ NO_____

   IF YES, PLEASE PROVIDE COPY OF THE REPORT.

   What is the report number? _____

   What law enforcement agency made the report? _____

   What is that agency's address and phone number? _____

   _____

******CONTINUED ON BACK PAGE******

INTEGRITY HOME CARE + HOSPICE GROUP HEALTH PLAN ACCIDENT QUESTIONNAIRE

8. Was any individual given a ticket or summons? YES_____ NO_____

   IF YES, PLEASE PROVIDE COPY OF THE TICKET OR SUMMONS.

   If YES, who and for what: _____

9. If yes, please indicate who the claim or action is against:

   NAME: _____

   INSURANCE COMPANY NAME, if applicable: _____

   INSURANCE COMPANY ADDRESS: _____

   _____

   CLAIM or POLICY #: _____

10. If Yes, please check whether the claim or suit is ONGOING: _____ CLOSED_____

    If ONGOING, provide your: Attorney's Name: _____

    Phone Number: _____

    Address: _____

    City, State, and Zip Code: _____

    If CLOSED, please provide details, including settlement amount or judgment award: _____

    _____

11. If you have not yet filed a claim or suit, do you intend to do so? YES_____ NO_____

I AUTHORIZE RELEASE OF INFORMATION TO MERCY BENEFIT ADMINISTRATORS FOR REVIEW AND I ATTEST TO THE ACCURACY OF THE INFORMATION CONTAINED WITHIN THIS FORM.

MEMBER SIGNATURE _____

DATE: _____/_____/_____

CLAIMANT SIGNATURE (IF CLAIMANT IS OVER THE AGE OF 18) _____

DATE: _____/_____/_____