

FCB BANKS GROUP HEALTH PLAN ACCIDENT QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AND RETURN TO:

**MERCY BENEFIT ADMINISTRATORS
PO BOX 14230
SPRINGFIELD, MO 65814**

FAX: 417-820-3816

email: sprgbenefitadmins@mercy.net

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******

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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: ____/____/____