COMPASS HEALTH
ADMINISTRATORS

ACCIDENT/ILLNESS QUESTIONNAIRE

Date:

Patient Name:
Address:
Address 2:

Patient Health Care ID:
Claim Number:
Patient:
Relationship:

Provider:
Address 1:
Address 2:

Accident Date:
Service Date(s):

Dear Participant,

Compass Health Administrators has partnered with the Phia Group to collect details regarding the above referenced claim. In accordance with your plan requirements and to control healthcare costs, we use the information requested to ensure no other entity is responsible for payment of your claims, as well as pursue reimbursement for your health plan in the event another party is responsible for these costs. Please complete and return the enclosed materials to the address listed below at your earliest convenience.

- Questionnaire

PLEASE NOTE: FAILURE TO RETURN THE COMPLETED AND SIGNED QUESTIONNAIRE MAY RESULT IN DENIAL RELATED CHARGES.

Your assistance with this matter is greatly appreciated. Should you have any questions please do not hesitate to contact us at the number listed on your health plan ID card, or via our website at www.compasshealthadministrators.com.

Thank you,

Claims Department
Compass Health Administrators

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Please check the appropriate box below, complete forms as instructed, and return this questionnaire to Compass Health Administrators.

☐ The accident/illness IS due to fault of another party. Please complete entire questionnaire and the attached reimbursement agreement.

☐ The accident/illness IS NOT due to the fault of another party. Please only complete Sections 1 -3.

SECTION I – PATIENT INFORMATION

1. Patient Name:	2. Patient Date of Birth:	3. Patient ID #:
4. Patient Address (Street/City/State/ Zip):	5. Patient Phone:	6. Alternate Phone:
7. Parent/Guardian Name (If Patient under 18 yrs of age): ☐N/A	8. Subscriber Name: ☐ Same as Patient	9. Patient Relation to Subscriber: ☐ Self ☐ Spouse/Domestic Partner ☐ Child ☐ Other: _____

SECTION II – GENERAL INFORMATION

10. Date of Accident, Injury or Onset of Illness:	11. Please check one: ☐ Auto Accident ☐ Other Accident/Injury ☐ Illness
12. Briefly describe how accident/injury occurred.	
13. Where did the accident occur?	
14. Who was at fault in the accident/injury?	
15. What were your injuries?	
16. Were you wearing any required safety equipment such as seatbelt or helmet? ☐ Yes ☐ No	

SECTION III – CLAIMS INFORMATION

17. Did you or will you be filing a claim with: ☐ Auto policy (including you own) ☐ Homeowner policy (including your own) ☐ Business ☐ Person(s)	If you have or will be filing a claim please identify who the claim or action is against and insurance company, business, or person(s) below: Name (of policyholder if applicable): _____ Insurance Company, Business, or Person(s): _____ Address: _____ Phone Number: _____ Claim or Policy Number: _____
18. Do you have any medical pay coverage on your own auto or homeowners policy?	☐ Yes ☐ No (If **YES**, provide the carriers name, address, phone number, and your policy number) Carrier Name: _____ Address: _____ Phone Number: _____ Policy Number: _____

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ACCIDENT/ILLNESS QUESTIONNAIRE

HEALTH CARE ID: _____

SECTION IV – LEGAL INFORMATION

19. Have you contacted an attorney?	☐ Yes ☐ No (If **YES**, provide the attorney's name, address, and phone number below). Attorney Name: _____ Address: _____ Phone Number: _____
20. If a lawsuit has been filed, briefly describe the status of the case. (*If your case has been settled, provide details and a copy of any settlement amount or judgment award*.)	

SECTION V – WORK RELATED ACCIDENT/INJURY

21. Is the accident/injury work related?	☐ Yes ☐ No (If checked skip Question 22) If **Yes**, please identify below if when the accident/injury occurred you were: ☐ at work ☐ travelling for work ☐ at a required work-sponsored event
22. Have you filed a Worker's Compensation Claim:	☐ Yes ☐ No If **yes** complete the information below: Claim/Appeal #: _____ Status of Claim/Appeal: ☐ Open ☐ Closed Name of Work Comp Carrier: _____ Address: _____ Phone Number: _____

I, _____, DO CERTIFY BY MY SIGNATURE THAT THE INFORMATION SUBMITTED ON THIS QUESTIONNAIRE IS TRUE AND CORRECT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION RELATING TO THIS INCIDENT TO, AND BY, MY PLAN ADMINISTRATOR, CLAIMS ADMINISTRATOR AND THE PHIA GROUP.

_____ _____

Signature Date

_____ _____

Print Name Primary Telephone Number

_____ _____

Print Name Alternate Telephone Number