Accidental Injury Questionnaire

Patient Name:_____ **ID/SS#:**_____

If you are filing your claims with your group health plan it will have a reimbursement provision for claims resulting from an act or omission of a third party. The term "third party" can be a person, a business, or other entity.

In most cases, the third party has insurance to cover your claims. The medical expenses that your group health plan pays which are also paid by the third party's insurance may need to be reimbursed to your group health plan.

Please Complete Section 1

Section #1

1. **Is this physical therapy care the result of an accidental injury caused by a third party? Yes No**

***** If your answer is no, please sign at ► below ** **If your answer is yes, complete 2-7 below*****

2. Date of Accident:_____Time:_____Location:_____
3. Is your condition the result of an auto accident? _____Yes _____No
   *If yes, complete **Section 2 & 3**
4. Is your condition the result of a third party incident? _____Yes_____No
5. Is your condition the result of your employment?_____Yes _____No
   *If yes, complete **Section 4**
6. Do you plan to collect damages as a result of this condition? _____Yes _____No
7. Has settlement been made on this condition already? _____ Yes _____No
   If yes, what date was settlement made? _____

Section #2

If your condition was caused by a Motor Vehicle Accident, your claims may be covered by **your** Personal Auto Policy, Medical Pay, or Personal Injury Protection. Please complete this section regarding **your** automobile insurance. If this accident involves a third party, please complete Section 3 also.

1. Policyholder Name:_____Policy#:_____
2. Auto Insurance Name:_____Phone:_____
3. Agents Name:_____
4. Do you carry Personal Injury Protection and/or MedPay ? ☐Y ☐N Limit $_____
5. Do you carry Uninsured Motorist? ☐ Y ☐ N Limit $_____

Section #3

If a Third Party was involved in the accident, you must furnish the following information.
I hereby authorize any third party or insurer to reimburse my group health plan for benefit payments made on my behalf as a result of this accident involving myself and/or my dependents.

1. Name and Address of 3rd Party:_____
2. Name of 3rd Party Insurance Carrier:_____
3. Address, City, St, Zip of Ins. Carrier:_____
4. Adjuster Name:_____Phone:_____Claim #:_____
5. Name of your Attorney: _____Phone:_____

Section #4

If your condition was caused by your employment, you must furnish all the information below.

1. Name and Address of your Employer: _____
   _____Phone:_____

2. Name and Address of your Employers Workers Compensation Carrier:
   _____

   _____Phone:_____

3. Your Workers Compensation Claim or Case Number: _____
4. Your Workers Compensation Case Nurse Name and Phone Number:
   _____Phone:_____
5. Your Workers Compensation Adjustor Name and Phone Number:
   _____Phone:_____

If your Workers Compensation claim has been denied, attach a copy of the denial when sending claims.

In regards to 3rd party claims resulting from a Motor Vehicle Accident and/or Personal Injury, please be advised that our Billing Office may file a lien to protect payment of our services. If you have any questions or concerns regarding this process, please contact our Billing Office at (405) 579-1600.

IF CONDITION WAS RELATED TO A MOTOR VEHICLE ACCIDENT, WORKERS COMPENSATION, OR THIRD PARTY, PLEASE SIGN HERE:
These answers are true and complete to the best of my knowledge.

Patient Signature:_____Date:_____

If patient is a minor or requires guardianship, Parent or Guardian must sign below:

Parent/Guardian Signature:_____Date:_____

SIGN BELOW IF CONDITION WAS NOT CAUSED BY A THIRD PARTY:

►Patient Signature: _____Date:_____

If patient is a minor or requires guardianship, Parent or Guardian must sign below:

►Parent/Guardian Signature:_____Date:_____