DELTA HEALTH SYSTEMS

Accident/Illness Questionnaire

Insert Date

Claim #: Insert Claim Number

Healthcare ID #: Insert Healthcare Id

Insert Patient Name

Patient: Insert Patient Name

Insert Address

Relationship: Insert Relationship

Insert City State Zip

Service Dates: Insert Service Dates

Provider: Insert Provider Name

Accident Dates: Insert Accident Dates

Dear Participant:

Delta Health Systems has partnered with the Phia Group to collect details regarding the above referenced claim. We ensure that no other entity is responsible for payment of your claims, pursue reimbursement on your plan's behalf when someone else is responsible, and return the funds to your plan in an effort to control healthcare costs. Please **complete** and **return** the enclosed materials to the address shown below:

- Questionnaire

IMPORTANT: Failure to return the signed Questionnaire may result in denial of related charges.

Your assistance in this matter is appreciated. If you have any questions, please call the number shown below, we would be happy to assist you.

Thank you,
Claims Department
Delta Health Systems

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Claim#: Insert Claim Number

Healthcare ID #: Insert Healthcare Id

Questionnaire

If this accident/illness is due to any fault of another party please complete and return this form. If this accident/illness is NOT due to the fault of another party please only complete questions 1 – 9.

1. Patient Name	Insert Patient Name
2. Relationship to Participant	Insert Relationship
3. Date of Accident, Injury or Onset of Illness	
4. If due to an accident/injury, please provide details of how the accident/injury occurred.	
5. Where did the accident, injury or onset of illness occur? (place/location/street)	
6. Who was at fault in the accident/injury?	
7. What were your injuries?	

Legal/Claims Information	
8. Did you, or are you going to, file a claim against any: ☐ Auto policy, including your own? ☐ Homeowner policy, including your own? ☐ Business ☐ Person(s)	◯ Yes ◯ No **If yes**, please indicate who the claim or action is against (name of policy holder, if applicable). Name, address and phone number of the insurance company, business or person(s): Claim or policy number
9. Do you have any medical pay coverage on your own auto or homeowners policy?	◯ Yes ◯ No **If yes**, please provide the carrier's name, address, phone number and your policy number.
10. Have you contacted an attorney?	◯ Yes ◯ No **If yes**, please provide your attorney(s) name, address and phone number.
11. If a lawsuit has been filed, what is the status of the case?	
If your case has settled, please provide details and a copy of any settlement amount or judgment award.	

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Work-Related Questions	
12. At the time of the accident or onset of illness, were you: ▪ at work, ▪ traveling **for** work, or ▪ at a required work-sponsored event?	◯ Yes ◯ No **If yes**, have you filed a Workers Compensation Claim?
	If yes, please provide: Claim/Appeal #: Status: ◯ Open ◯ Closed
	What is the name, address and phone number of the workers comp carrier?

Accident-Related Questions	
13. Were you wearing any required safety equipment, such as a seatbelt or helmet?	◯ Yes ◯ No Comment:
14. Was a motor vehicle involved?	◯ Yes ◯ No **If Yes**, please include a police report with the TPL letter.

I hereby acknowledge and agree to the terms of my plan's subrogation, reimbursement and/or third party recovery provision(s). 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

_____ E-Mail

_____ Print Name

_____ Primary Telephone

_____ Alternate Telephone