**Please complete and return to one of the following:**

Email: claims@partnersmgu.com
Fax: 480.750.1395

# Accident Questionnaire Form

Insured Name: ______________________ Claimant Name: ______________________

Employer/Group Name: ______________________ Date of injury or illness: ____________

Dear Insured:

Our review process indicates the above claimant may have received healthcare services related to an accident. In order to evaluate our responsibility, please complete, sign and return this form along with any police reports, accident details, and attorney letters if applicable.

If you have previously completed a form for this accident, please check here ☐ and update.

**Type of injury or illness**: **Other Accident ☐** **Auto/Motorcycle Accident ☐** **Work Related ☐** **No Accident ☐**

______________________________________________
City/County and State of Injury

______________________________________________
Describe the injury or illness and where and how it happened

______________________________________________
Names of other family members injured

**If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:**

Did another Person, other than the insured, cause this accident? ☐ Yes ☐ No

If Yes, please fill out the following with information regarding the Person causing the injury.

| Full Name | Street | City | St | Zip |
|---|---|---|---|---|

| Insurance Company | Policy/Claim # | Phone Number |
|---|---|---|

| Adjuster's Name | Street | City | St | Zip |
|---|---|---|---|---|

**If you checked "Auto/Motorcycle Accident", please answer the following:**

Was the claimant wearing a seatbelt? ☐ Yes ☐ No Was the claimant wearing a helmet? ☐ Yes ☐ No

Has the insured filed a claim with the Auto Insurance Company? ☐ Yes ☐ No

Was the claimant the driver or a passenger? ☐ Driver ☐ Passenger

| Auto Insurance Company | Policy/Claim # | Phone Number |
|---|---|---|

| Adjuster's Name | Street | City | St | Zip |
|---|---|---|---|---|

**If you checked "Work Related," please answer the following with the information at the time of injury:**

Employer's Name | Street | City | St | Zip

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

If Yes, please fill out the following with information regarding the Workers' Compensation Claim.

Workers' Compensation Carrier | Policy/Claim # | Phone Number

Adjuster's Name | Street | City | St | Zip

Has the employer or the Workers' Compensation Carrier accepted or denied liability? ☐ Accepted ☐ Denied

**Have you retained an attorney for your injuries:** ☐ Yes ☐ No

**If yes, please provide the attorney's information below:**

Attorney's Name | Phone Number

Attorney's Street | City | St | Zip

**I certify the above information is correct, and I will not settle a claim before contacting the Claims Department at Partners MGU.**

Insured Signature | Phone Number

Insured Name (Printed) | Date

# Frequently Asked Questions

**Why do we need this information?**

Your health contract contains an important clause called “subrogation” or “reimbursement.” This means when Partners MGU pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, their insurance company, and/or your insurance company. We also have the right to seek reimbursement of the medical bills from you if you receive a settlement from the third party or an insurance company for this injury or illness.

*To the extent that benefits are provided or paid under this Policy, we shall be subrogated to all rights of recovery which any Covered Person may acquire against any other party for the recovery of the amount paid under this Policy, however, our right of subrogation is secondary to the right of the Covered Person to be fully compensated for his damages. The Covered Person agrees to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action We may require facilitating enforcement of our right of subrogation. We agree to pay our portion of the Person Person's attorneys' fee or other costs associated with a claim or lawsuit to the extent that we recover any portion of the benefits paid under this policy pursuant to our right of subrogation.*

**How did we identify your claim as a potential subrogation or workers’ compensation case?**

Our staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident related or work related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these “accident-type” diagnosis codes.

**How does subrogation help you?**

These subrogation/reimbursement procedures help to contain the cost of healthcare by reducing premium costs paid by you and/or your employer and also reducing the amount of benefits applied to your lifetime maximum benefit amount.

**What if you were injured on the job?**

Your health contract also contains a provision that excludes the payment of medical bills for work-related injuries and illnesses. This means that we will not provide benefits if workers’ compensation laws cover, provide or pay for the service, supply or treatment of any work-related accident or illness. In addition, if you receive a settlement for your workers’ compensation claim, we consider the settlement payment to be covered by workers’ compensation and we will not provide medical benefits for the injury or illness.

**Does this questionnaire only apply to work-related accidents?**

No. If another person caused your injury or illness or may be responsible for your injury or illness, you need to complete this form. We cannot provide you with an entire list, but here are just a few of the types of accidents we need to know about: car accidents, motorcycle accidents, work-related injuries, injuries on another person’s property (such as falling in the grocery store), medical malpractice, defective products or machinery, food poisoning, etc.

**What if this claim was not accident related or if no one else was responsible for the injury or illness?**

The only way we will know if your claims are or are not accident related is if you complete and return this form. After we receive your information indicating this was an illness for which no one else is responsible, we will make sure your claims are opened for processing and we will notate your information in our system to avoid having future questionnaires sent to you for the same accident.

**What do you need to do?**

It is very important that you complete this easy questionnaire and send it back to us. Your answers will help us properly administer your claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If you do not return the questionnaire, we may withhold payment on your medical claims.

The subrogation/reimbursement and workers’ compensation clauses in your health contract require you to notify us if you receive an award or settlement from a third party or an insurance company. From that award or settlement, you must reimburse Partners MGU for any medical benefits that we have paid for this injury or illness.

Please contact us at 480.237.3613, for more assistance.