1419 Hampton Ave
St. Louis, MO 63139

MEMBER NAME:
ADDRESS:

CLAIM #
LETTER: SUBROCARP
GROUP #: 76415833
ID#
PATIENT
DOB
PROVIDER :
SERV DT:

Accident / Injury Questionnaire

St. Louis - Kansas City Carpenters Regional Health Plan (Carpenters Plan)
1419 Hampton Avenue, St. Louis, MO 63139
Phone : (314) 644-4802 Email : benefits@laborfunds.org Fax : (314) 678-1110

We recently received a claim for the patient listed below that may be the result of an accident or injury.
We need additional information before we can process this claim.
We need you to **fully complete, sign, and date** the enclosed Questionnaire.

A: Patient Information
First and Last Name Date of Birth Last Four of Social Security

◯ I am the Member ◯ I am the Member's Spouse ◯ I am the Member's Dependent

B: What was the injury/accident/illness/reason for this claim? (We must have this information to process the claim)

C: When did the described injury/accident/illness occur (Date): _____

D: Did this happen while patient was work, including self-employment? ◯ Yes ◯ No

E: Did this happen while patient was at school? ◯ Yes ◯ No

If **YES**, does the school carry Excess plan coverage for student injuries? ◯ Yes ◯ No

School Information:
Name: _____
Address:_____
Contact:_____

Reset form

F: Was this injury/accident related to a motor vehicle accident? ◯ Yes ◯ No

G: For ANY motor or recreational vehicle accident, please answer the following:

- Were you the driver or passenger?
  ◯ **Driver** ◯ **Passenger**
- Were other vehicles involved?
  ◯ **Yes** ◯ **No**
- Was the treatment related to competition racing or extreme sports?
  ◯ **Yes** ◯ **No**
- Were you under the influence of drugs or alcohol at the time of the injury?
  ◯ **Yes** ◯ **No**

If applicable to your injury/accident/illness, please provide the following documents:

- **Police Report, police citation/tickets, or victims Assistance Statements related to the injury/illness.**
- **Any relevant correspondence from the insurance company regarding the injury/illness.**
- **A copy of the auto insurance declaration.**

H: Have you retained an attorney? ◯ Yes ◯ No

Attorney Name: _____
Address:_____
Phone/Fax Number: :_____

I: Did the accident injury occur on public or private property? ◯ Private ◯ Public

If this claim may be the result of another party's negligence, please provide the name of the third party below and the contact details.

Name of Third Party: _____
Responsible Party's Insurance Carriers:_____
Policy Number: _____
Claim Number: _____
Adjuster Name: _____
Insurer address/phone/fax: _____

Have you received any payment/settlement in connection to this injury? ◯ Yes ◯ No

If yes, please provide the settlement date: _____

MD

I HEREBY CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE. I AUTHORIZE YOU TO OBTAIN ANY INFORMATION THAT MAY BE RELATED TO THIS ACCIDENT.

In accordance with the provisions of this Health Plan, I agree that if payment should be received from any other person or organization responsible for injuries sustained, whether by legal actions, settlement or otherwise, I will reimburse the Plan to the extent of the benefits provided, immediately upon receipt.

I also authorize and direct reimbursement to you of the amounts otherwise payable to me or on my behalf to others, but not to exceed the benefits paid under this Health Plan, as a result of the injuries sustained.

Plan Member's Signature:_____Date_____

Patient Signature (if over 18):_____Date_____

Please provide a daytime phone number in case additional information is needed:_____

Thank you for your help. If you have any questions, pelase contact the Benefits Office at (314) 644-4802.