ONE TEAM HEALTH

Medical Accident Questionnaire

A. Patient Information

Last Name	First Name	Alias

Date of Birth (MM/DD/YY)

Member ID Number	Policyholder name (if different than patient)	Are you a full time Student
		Yes No

Date of Accident
Detailed description of how accident occurred (use back if more space is needed):
Where did the accident occur?
1) Was any other person responsible for causing your accident?
Yes No
If yes, please explain
2) Were you under the influence of drugs or alcohol at the time of accident?
Yes No
3) Was this a sports related injury?
Yes No
Did this injury happen while playing recreational sports (fun or playing with your friends etc.)?
Yes No
Does the sports involve a high degree of risk?
Yes No
Did this injury happen while playing school Sports/School Activity?
Yes No
Did this accident happen in a public venue such as restaurant, gym, work?
Yes No

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4) Is there another insurance plan with potential financial liability for this injury (i.e. Workman's compensation, automobile, property insurance)?	
Yes No	
If YES, please provide the following details for the other plan	
Policy Holder	Policy Number
Plan Name	Contact Number

B. Acknowledgment and Fraud Warning

I can confirm that the information I have provided in this form, is true to the best of my knowledge, information, and belief. I acknowledge that if any fact is found to be untrue that this may impact my eligibility or processing of my claim. Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Patient Signature | Date (MM/DD/YY)

PLEASE ATTACH THE OFFICIAL POLICE ACCIDENT REPORT IF APPLICABLE.