



PO Box 3507
Missoula, MT 59806-3507
1-800-737-3137 or (406) 523-3122

Date: _____

Claim #: _____

Name of Treating Physician: _____

Date of Service: _____

Injured Person: _____

Name of Employer/Plan Sponsor: _____

Policyholder: _____ Participant ID #: _____

Dear _____,

We have received the above claim indicating a possible accident or injury. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted and Montana Law, we must receive this information within 45 days of the date of this letter or the claim will be denied. Our fax number is 1-866-201-0522.

ACCIDENT/INJURY QUESTIONNAIRE

Was the above date-of-service the result of an accident/injury? ___Yes ___No

If no, please explain: _____

***IF YES, PLEASE LIST THE DATE OF THE ACCIDENT/INJURY: _____

Please describe how the accident/injury occurred: _____

Please describe where the accident/injury occurred: _____

If accident/injury took place on a premises other than your property, is there homeowner or premises insurance available? ___Yes ___No

If yes, please give details: _____

Please describe what body parts were involved in the accident/injury: _____

Did the accident/injury happen while you were working? ___Yes ___No

If yes, has the employer been notified? ___Yes ___No

If yes, please list the date the employer was notified: _____

If the accident/injury happened while you were working, please describe the circumstances of the Accident/injury: _____

Was the accident/injury the result of a motor vehicle accident? ___Yes ___No



Group #:
Participant ID #:
Patient Name:

Were you the: ___Driver ___Passenger ___Pedestrian
Driver's Name:
Policyholder's name if not the same as driver:
Auto Insurance Company: Phone #:
Claim Number:
Was a traffic citation issued? ___Yes ___No If yes, to whom:
Is there medical coverage available through the automobile insurance policy? ___Yes ___No
If yes, how much? \$ Number of vehicles involved:

Is there other insurance coverage (other than listed above) available for the accident/injury? ___Yes ___No

If yes, please provide the following information-
Name of other insurance company:
Address:
City, State, Zip:
Area Code and Phone Number:

Is another party liable for the accident/injury? ___Yes ___No
If yes, please provide the following information:
Name:
Address:
Area Code and Phone Number:

Do you intend to retain an attorney? ___Yes ___No
If yes, please indicate the legal counsel's name, address, and phone number:
Name:
Address:
Area Code and Phone Number:

Is there anything else you would like us to know about this accident/injury? Please explain:

Your phone number: ()
Additional phone number where you may be reached: ()

The above information is true to the best of my knowledge:

Signature of injured person Date
(if injured person is less than 18 years of age then a parent or guardian must sign)

Printed name of person signing above