CentegraHealthSystem

Accident Questionnaire

To be completed entirely by the Patient/Guardian.

- **All fields must be completed or indicate unknown or N/A for Not Applicable.**

Are you seeking treatment for an accident-related injury?(Check box) ☐ **Yes** ☐ **No** ☐ **Unknown/Maybe**

☐ **WORK-RELATED** **or** ☐ **PERSONAL INJURY (TORT)**

Has the Illinois/state Report of Occupational Injury or Illness (WC) form OR other Report been completed?

☐ Yes, Type of Report: _____ Claim #_____, Filing Date _____

☐ No – Patient needs to file a claim, fill out form, and submit within 7 days or WC filing date. Without information submittal, account is your responsibility/Self Pay.

☐ Unknown – Decision must be submitted within 7 days or WC filing date. Without information submittal, account is your responsibility (Tort may have Medical Insurance applied.)

Will you be filing a claim for this accident?	☐ Yes: Claim/Issue Number _____ ☐ No, advise of decision in 7 days or WC filing date; otherwise account is your responsibility.

IF WORK-RELATED INJURY or PERSONAL INJURY (TORT), complete the following:

Date of Work-Related or Personal Injury:			
Where did Injury happen (Location/Address):			
What type of Injury do you have:			
Lawyer (if any) Address & Ph.#:			
Who is your Employer or Liability Party (Contact Info):		Agent/Person Phone #:	
Name of Compensation Insurance:		Adjuster & Ph. #:	

☐ **AUTO ACCIDENT** ☐ **MOTORCYCLE** ☐ **BOAT** ☐ **LAND or DIRT 4-WHEELER** ☐ **SNOW or Water Machine**

☐ **OTHER (Bus, Commercial Vehicle, etc.)** _____

Were you the: Driver _____ Passenger _____ Pedestrian _____

Date of Accident: _____ Police Report # _____ Number of Vehicles in Accident: _____

Where was the Location/Address of Accident: _____

What type of Injury(ies) do you have: _____ Policyholder Name & ID# _____

Name of Insurance: _____ Insurance company's address _____

Insurance Claim Number _____ Adjuster & Ph.#: _____ Phone #: _____

Lawyer (if any) Address & Ph.#: _____ Insurance Agent: _____

Do you intend to make a claim for your injury(ies) or condition? (Medical Information is required as well.)

☐ Yes; When will you file your claim? (or you will be billed). _____

☐ No; Medical Insurance Information Required or you will be bill billed for the entire claim.

☐ Unknown; Decision must be submitted within 7 days. Without information submittal, account is your responsibility.

☐ **To the best of my knowledge the above listed information is correct**:

Printed Name:_____ Date _____ D.O.B. _____

Signature: _____

If you have questions regarding the questionnaire, please call (866) 642-9518

PC1214010 05-15 **Send to: Centegra Primary Care, LLC PO Box 187 Bedford Park IL 60499-0187**