



First Choice Health—MUST
P.O. Box 12569
Seattle, WA 98111-4659

Date: _____

| | |
|--------------------------------|---------------------------------|
| Claim Number (if known): | Name of Treating Physician: |
| Date of Service: | Injured Person: |
| Name of Employer/Plan Sponsor: | Injured Person's Date of Birth: |
| Participant Name: | Participant ID Number: |

Dear _____,

We have received the above claim indicating a possible accident or injury. Your MUST medical plan includes an accident benefit that may provide payment without meeting the medical deductible, depending upon the circumstances of the injury. To help us determine whether you are eligible for this benefit, please complete this questionnaire and return it to the address above.

We must receive this information within 45 days of the date of this letter or the claim will be denied. Thank you for your prompt attention to this request.

ACCIDENT / INJURY QUESTIONNAIRE

On the Date of Service above, was the service provided as a result of an accident/injury? _____ Yes _____ No

If no, please explain: _____

If yes, what was the date of the accident/injury? _____

Where did the accident/injury occur? _____

What body parts were involved in the accident/injury? _____

Did the accident/injury happen in the workplace? _____ Yes _____ No

If yes, have you notified the employer? _____ Yes _____ No

If yes, list the date on which the employer was notified: _____

Please describe the circumstances of this accident/injury in the workplace:

(continued on reverse)

Was the accident/injury the result of a motor vehicle accident? _____ Yes _____ No
If yes, was the injured person: _____ the driver? _____ a passenger? _____ a pedestrian?
Driver's name: _____
Policyholder's name, if not the same as driver's name: _____
Auto Insurance Company: _____ Phone #: _____
Auto Insurance Claim Number: _____
Was a traffic citation issued? _____ Yes _____ No If yes, to whom? _____
Is there medical coverage available through the auto insurance policy?
If yes, how much? \$_____ Number of vehicles involved: _____

Is there other insurance (other than listed above) available for the accident/injury? _____ Yes _____ No
If yes: 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: Name of liable party: _____
Address: _____
City, State, Zip: _____
Area code and phone number: (_____) _____

Do you intend to retain an attorney? _____ Yes _____ No
If yes: Name of attorney: _____
Address: _____
City, State, Zip: _____
Area code and phone number: (_____) _____

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

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

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

Date

Printed name of person signing above