



MONTANA UNIFIED SCHOOL TRUST

PO Box 3777

Missoula, MT 59806

1-800-437-8500 or (406) 721-2222

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.  
\_\_\_\_\_  
\_\_\_\_\_

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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