THIRD PARTY LIABILITY/ACCIDENT QUESTIONNAIRE FORM

Please supply the following information to ensure our billing records are correct and that claims are submitted properly. In the event ambulance services were provided as the result of an accident, please complete page two of this document.

Patient Name: **Call #:** **Date of Service:**

Patient Social Security No: _____-_____-_____

DOB: _____/_____/_____

Mailing Address: _____

_____

Home phone: _____-_____-_____

Mobile Phone: _____-_____-_____

City: _____ St: ___ Zip: _____

Email address: _____

The following persons are authorized to be contacted to discuss this account

Guarantor/Legal Guardian:

_____
Name

_____
Address

_____
Phone No

Other Contact:

_____ /_____
Name *Relationship*

_____
Address

_____
Phone No

Primary Policy Description: *(check one of the following as the primary payer)*

☐ Commercial/Group Health plan ☐ Workers' Compensation ☐ Tricare/CHAMPVA
☐ Black Lung ☐Crime Victims ☐ Indian Health ☐ Veterans Affairs

☐ Medicare _____ ☐ Medicare Advantage Plan _____
Beneficiary ID number from card Beneficiary ID number from card

☐ Medicaid _____ ☐ Medicaid Replacement Plan _____
Medicaid ID number from card Medicaid ID number from card

☐ Self-Pay/No health coverage ☐ Other Insurance:_____
Describe other coverage, EX tertiary/third party liability (complete section below)

Has patient or hospital applied for Medicaid or does the patient intend to apply? ☐ Yes ☐ No
Date of Medicaid application: ____/____/_____

Primary Policy Information
(Provide insurance information applicable to the item checked above)

Insurance carrier: _____
Name
_____
Address
_____
Phone

Print name as it appears on card: _____
Subscriber Name

Subscriber date of birth: _____/_____/_____

_____ / _____
Subscriber ID *Group #*

Secondary Policy Information
(Provide any secondary health insurance coverage)

Insurance carrier: _____
Name
_____
Address
_____
Phone

Print name as it appears on card: _____
Subscriber Name

Subscriber date of birth: _____/_____/_____

_____ / _____
Subscriber ID *Group #*

Tertiary or Other Insurance Policy Information
(Provide any tertiary, third party liability or other insurance coverage)

Other Insurance: _____
Name
_____
Address
_____
Phone

Print name as it appears on card: _____
Subscriber Name

Subscriber date of birth: _____/_____/_____

_____ / _____
Subscriber ID *Group #*

Accident Date:____/____/_____ **Accident Type:** ☐ Auto accident ☐ Employment related ☐ Other accident

Accident Location: _____
City, County, State, and Zip

Law Enforcement on scene? ☐ Yes ☐ No

Accident Details: _____
Ex: fall, burns, ATV, boating, altercation,etc. _____
_____

Auto Accident:

of vehicles involved: _____

Vehicle owner at fault, if known: _____
Name, Phone No

Patient Personal Auto Insurance:

_____
Company Name

_____
Adjuster Name, Phone No

_____ / _____
Policy No *Claim No*

Vehicle 1:

_____
Company Name

_____
Adjuster Name, Phone No

_____ / _____
Policy No *Claim No*

Vehicle 2:

_____
Company Name

_____
Adjuster Name, Phone No

_____ / _____
Policy No *Claim No*

Employment Related Accident:

_____
Employer Name

_____
Employer Address

_____
City, ST. Zip

_____
Phone No

Workers' compensation carrier:

_____
Company Name

_____
Adjuster Name, Phone No

_____
Claim No:

Name:
Call #: DOS:

Other Accident:

Did accident occur on patient's personal property ?
☐ Yes ☐ No
if No, Will a claim be filed to Third Party Liability? ☐ ***Yes*** ☐ ***No***

Property owner:

_____
Name

_____
Phone No

Third Party Liability Insurance:

_____
Name

_____
Address

_____
City, ST. Zip

_____
Phone No

_____ / _____
Policy No Claim No

_____
Adjuster Name, Phone No

Other Third Party Liability Insurance:

_____
Name

_____
Address

_____
City, ST. Zip

_____
Phone No

Is the patient a victim of a crime? ☐ Yes ☐ No

Has the patient applied for Crime Victims Compensation?
☐ Yes ☐ No

Is there an attorney involved to represent the patient regarding any of the matters listed above ?
☐ Yes ☐ No

_____
Attorney's Name

_____
Attorney's Address

_____
City, ST. Zip

_____
Phone No