



636 Solarex Court ♦ P.O. Box 1169 ♦ Frederick, MD 21702-0169 ♦ (301) 694-6060 ♦ Fax: (301) 694-0501

Date: _____

Name: _____
Address: _____

**CLAIMS INFORMATION
RESPONSE REQUESTED**

RE: Accidental Injury/Work-Related Medical Condition Questionnaire

Group ID: _____

Group Name: _____

Insured ID: _____

Insured Name: _____

Patient Name: _____

Dear _____:

We have received a claim for expenses for a patient with the following information:

Patient Name: _____

Provider Name: _____

Dates of Service: From: _____ To: _____

These charges appear to be the result of either **(A) an accidental injury, or (B) a work-related medical condition, or both**. Before we can properly determine benefits, please provide the following information for the appropriate section below:

SECTION A: ACCIDENTAL INJURY

(1) Was this treatment the result of an injury? _____ Yes _____ No

(a) If no, when and how did the condition originate?

(b) If yes, please provide the date and time of the injury.

Date _____

Time _____

(2) How did the injury occur? Please be specific as possible.



636 Solarex Court ♦ P.O. Box 1169 ♦ Frederick, MD 21702-0169 ♦ (301) 694-6060 ♦ Fax: (301) 694-0501

(3) Whose property were you on when the injury occurred?

Property Owner's Name _____

Address _____

Phone Number _____

(4) Was this injury or medical condition the result of an automobile or other motor vehicle injury? _____ Yes _____ No

(5) If the injury occurred while attending school or a school sponsored function, is the patient covered under a school insurance plan? _____ Yes _____ No

SECTION B: WORK-RELATED MEDICAL CONDITION

(6) Was the injury or illness in any way related to the patient's employment?

_____ Yes _____ No (If yes, please complete A – C below)

(A) To the best of your knowledge, are you covered by worker's compensation? _____ Yes _____ No

(B) Have you, or are you considering, filing a worker's compensation claim? _____ Yes _____ No

(C) Which would best describe your position within the company?

_____ Owner _____ Laborer

_____ Sole Proprietor _____ Clerical Worker

_____ Partner _____ Officer

_____ Other

If Other, please describe: _____

Signature _____

Date _____

Sincerely,

Claims Department

RETURN IN POST PAID ENVELOPE