First Choice Health—MUST
P.O. Box 12659
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