THERAPYPLUS
Physical and Occupational Therapy

Accident Questionnaire

Patient Name _____Date of Birth _____

Commercial Insurance; It's Madonna's policy to bill your health insurance. Please contact your health insurance at your earliest convenience to provide the required accident details.

Medicaid Patients; Accident information is required for all Medicaid recipients. Medicaid will require that we file a claim for 'medical payment' coverage and/or liability settlement prior to submitting claim to Medicaid.

Medicare Patients; Accident information is required for all Medicare recipients. Medicare claims cannot be submitted without this information, even if you are not intending to file a liability claim or law suit.

What type of accident caused your illness, injury or condition? Auto _____ Other ____

Have you filed, or do you intend to file, a liability claim or lawsuit related to this illness, injury, or condition?
Yes _____ No _____

Patient's Attorney (handling this claim) _____

Phone Number _____ Address_____

Section I Property Injury Information

If injured on your property, someone else's property or commercial property, please complete the following questions:

Date of Accident_____ Time of Accident _____ Specific Location _____

Brief description of accident:

_____
_____
_____
_____

Property Insurance Information

Property Insurance Company Name _____

Property Insurance Company Address _____

Phone Number _____ Policy/Claim Number _____

Section II for Automobile Accident Only

Date of Accident _____ Time of Accident _____ Number of Vehicles Involved _____

Patient was: Driver ____ Passenger _____ Bicyclist ____ Pedestrian _____ Other _____

Was a ticket issued? Yes _____ No _____ If yes, to whom? _____

Brief description of accident including the specific street names, city and state:

_____
_____
_____
_____
_____

Patient – Information

Patient's Vehicle Insurance Co.(even if a passenger, pedestrian or bicyclist)

Name _____ Vehicle Insurance Address _____

Phone Number _____ Policy/Claim Number _____

Adjustor Name _____ Phone Number _____

Medical Payment Coverage $ _____

Driver – Owner Information

Patient's Vehicle Insurance Co. (even if a passenger, pedestrian or bicyclist)

Name _____ Vehicle Insurance Address _____

Phone Number _____ Policy/Claim Number _____

Adjustor Name _____ Phone Number _____

Medical Payment Coverage $ _____

Section III – Other vehicle information if applicable

Owner of Vehicle Name _____ Address _____

Owner's Insurance Co. _____ Address _____

Phone Number _____ Policy/Claim Number _____

Adjustor Name _____ Phone Number _____

Medical Payment Coverage $ _____

Signature: _____

Name Relationship Date