Other Party Liability

Patient Information Form

Member Name: _____
Member's ID No: _____ Ins Provider: _____
Patient's Name: _____

We attempt to verify if your injury, condition and diagnosis is eligible to be covered by other insurance such as liability, worker's compensation or auto insurance in accordance with the regulations we must follow. Please answer the following questions:

Date of accident or onset of symptoms: _____

Description of injury (body part) or condition: _____

How did the injury / condition occur? _____
_____
_____
_____

Where did it occur? ___School ___Home ___Work
___Other (explain) _____

Was your accident / condition work related? ___Yes ___No

IF YES, are you self-employed? ___Yes ___No

Was the injury the result of a motor vehicle accident or physical contact with a motor vehicle? ___Yes ___No

IF YES, are you a titled owner? ___Yes ___No
IF YES, type of vehicle involved? ___Car ___Truck ___Motorcycle
If motorcycle: Are you the owner? ___Yes ___No
If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ___Yes ___No

Was another party responsible for your injury or condition? ___Yes ___No

If yes, explain: _____
_____
_____

Coordinating benefits places responsibility with the proper carrier, which helps keep rates lower for our customers.

YOUR SIGNATURE _____ Date _____