Claim # _____

WELLSPAN HEALTH
Population Health Services

Claim Questionnaire

This form can be completed online at www.WellSpanPopHealth.com OR you can submit this form to our Customer Service Department: at PO Box 2347, York, PA 17405 OR via fax to (717) 755-7190.

Questions: Call us at • (717) 851-6800 or (800) 842-1768.

Please fill out the sections that pertain to the claim that is in question.

A. SUBSCRIBER INFORMATION (Please print clearly.)

Subscriber (employee) name _____ *Family ID #* _____

Subscriber's Employer _____*Subscriber Phone number* _____

B. Patient Information

Patient Name_____ Date of Birth_____

C. General Information

Date of Accident or Onset of Condition_____

What body part or condition is being treated?_____

Was the condition related to any of the following:

☐ A work accident or illness ☐ An automobile accident ☐ A motorcycle accident ☐ Other vehicle accident
☐ School related accident ☐ An injury caused by another party ☐ An accident at someone else's home
☐ Accident at a business establishment, other than the employer's ☐ Not an accident
☐ Other (explain): _____

Briefly describe the accident/incident or the onset of the condition, including the location/address:

_____
_____
_____

D. Complete If You Checked Work Accident or Illness (Must provide denial from workman's compensation.)

Name and address of patient's employer at the time of accident_____

_____

Has a Workman's Compensation claim been filed? Yes__No__Original date of accident/illness / /

Name, Address, Phone Number of the patient's attorney, if applicable:_____

E. Complete If You Checked Automobile/Motorcycle/Other Vehicle Accident (Must provide exhaustion letter and payout sheet from insurance company for consideration under this Plan.)

The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other (explain): _____

The vehicle was a: ☐ Automobile ☐ Motorcycle ☐ ATV ☐ Other (explain): _____

Did another person cause the accident? ☐ Yes ☐ No

If yes, provide the name and address of the person who caused the accident: _____

Insurance name, address and policy number of the at-fault person: _____

Does the patient have vehicle insurance? ☐ Yes ☐ No

If yes, provide the insurance name, address and policy number: _____

Does the patient's vehicle insurance include medical coverage? ☐ Yes ☐ No

List any other members on this Plan that were involved in the accident: _____

Name, address and telephone number of the patient's attorney, if applicable:

_____

A copy of the police report must be included with this form. If there is no police report, please provide the reason why: _____

Claim # _____

F. Complete If You Checked Any Other Kind of Accident (If police report filed, supply a copy.)
Did the accident occur on someone else's property? ☐ Yes ☐ No ☐ Other (explain): _____

Was the accident the fault of another person or a business? ☐ Yes ☐ No
If yes, please explain: _____

Have you filed an insurance claim with the at-fault party or do you anticipate filing a claim? ☐ Yes ☐ No
If yes, please provide the name and address of the at-fault party: _____

Name, address and policy number of the at-fault party's insurance carrier: _____

List any other members on this Plan that were involved in the accident: _____

Name, address and telephone number of the patient's attorney, if applicable: _____

_____

G. SUBSCRIBER SIGNATURE
I understand that if I, or any of my covered dependents, have been in an accident or injured by another party, or have a work-related accident or illness, the benefits of my Plan will be available subject to its terms, conditions and exclusions and I hereby authorize any party or insurer to reimburse my group health plan for any benefit payments made on my or my dependent's behalf. I also understand that my Plan contains a Third Party Reimbursement/Subrogation provision and I agree to cooperate with the Plan with any efforts to recover benefits from the responsible party.

I certify that the above information is correct and understand that I am obligated to provide this information according to the provisions of the Plan. Failure to provide complete and accurate information will result in a delay in the processing of benefits.

Printed Name:_____

Signature:_____Date_____

Caution: Any person who knowingly and with intent to defraud any health plan, insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.