INJURY/ACCIDENT QUESTIONNAIRE

PLEASE COMPLETE THE INFORMATION BELOW IN REFERENCE TO A CLAIM THAT COULD BE RELATED TO AN ACCIDENT. **THEN RETURN THIS FORM BY FAX TO 614-863-0184, EMAIL TO BACINFOREQ@BACTPA.COM OR SUBMIT IT VIA OUR PORTAL AT BACTPA.VBAGATEWAY.COM**

A. MEMBER'S INFORMATION:

BAC MEMBER'S NAME (LAST, FIRST, M.):

BAC MEMBER ID NUMBER:

MEMBER'S ADDRESS:

CITY:

STATE:

ZIP CODE:

EMPLOYER'S NAME:

MEMBER'S EMAIL ADDRESS (USER@DOMAIN.COM):

WERE THE SERVICES RELATED TO AN INJURY/ACCIDENT?

◯ **NO** ◯ **YES, PLEASE COMPLET SECTION B**

B. ACCIDENT INFORMATION:

PATIENT'S NAME (LAST, FIRST, M.):

PATIENT'S D.O.B. (MM/DD/YYYY):

DATE OF INJURY/ACCIDENT (MM/DD/YYYY):

TIME OF INJURY/ACCIDENT :

HOW DID THE INJURY/ACCIDENT OCCUR (BRIEF DESCRIPTION)? :

WHERE DID THE INJURY/ACCIDENT OCCUR:

DID THE INJURY OCCUR WHILE ON THE JOB:

◯ **NO** ◯ **YES**

WAS A POLICE REPORT FILED?

◯ **NO** ◯ **YES, PLEASE ATTACH A COPY OF THE POLICE REPORT.**

IS ANOTHER INSURANCE CARRIER LIABLE? (LIST OTHER GROUP INSURANCE CARRIER UNDER WHOM YOU MAY FILE A CLAIM OR SUIT.)

◯ **NO** ◯ **YES, LIST INSURANCE CARRIER:**

ARE YOU PURSUING A CLAIM OR LAWSUIT AGAINST ANY PARTY(S) WHO CAUSED OR CONTRIBUTED TO YOUR ACCIDENT?

◯ **NO** ◯ **YES, YOUR ATTORNEY'S NAME:** **PHONE NUMBER:**

PLEASE NOTE THAT ALL CLAIMS PAID BY YOUR EMPLOYER SPONSORED HEALTH PLAN SHOULD BE REIMBURSED BACK TO YOUR EMPLOYER IN THE EVENT OF A MONETARY SETTLEMENT. YOUR ATTORNEY CAN EXPLAIN THE PROCESS OF RETURNING MONEY TO YOUR HEALTH PLAN IN THE EVENT OF A SETTLEMENT.

C. SIGNATURE:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

X _____ _____

SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.