PO Box 3507
Missoula, MT 59806-3507
1-800-737-3137 or (406) 523-3122

Date:

Claim #: _____
Name of Treating Physician: _____
Date of Service: _____
Injured Person: _____
Name of Employer/Plan Sponsor: _____
Policyholder: _____ Participant ID #: _____

Dear _____ ,

We have received the above claim indicating a possible accident or injury. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted and Montana Law, we must receive this information within 45 days of the date of this letter or the claim will be denied. Our fax number is 1-800-877-1122.

ACCIDENT/INJURY QUESTIONNAIRE

Was the above date-of-service the result of an accident/injury? ☐ Yes ☐ No
If no, please explain: _____
_____
_____

***IF YES, PLEASE LIST THE DATE OF THE ACCIDENT/INJURY: _____
Please describe how the accident/injury occurred: _____
_____
_____
_____

Please describe where the accident/injury occurred: _____
_____

If accident/injury took place on a premises other than your property, is there homeowner or premises insurance available? ☐ Yes ☐ No
If yes, please give details: _____
_____
Please describe what body parts were involved in the accident/injury: _____
_____

Did the accident/injury happen while you were working? ☐ Yes ☐ No
If yes, has the employer been notified? ☐ Yes ☐ No
If yes, please list the date the employer was notified: _____
If the accident/injury happened while you were working, please describe the circumstances of the Accident/injury: _____
_____
_____
Was the accident/injury the result of a motor vehicle accident? ☐ Yes ☐ No

Allegiance℠
Benefit Plan Management

Group #:
Participant ID #:
Patient Name:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian
Driver's Name: _____
Policyholder's name if not the same as driver: _____
Auto Insurance Company: _____ Phone #: _____
Claim Number: _____
Was a traffic citation issued? ☐ Yes ☐ No If yes, to whom: _____
Is there medical coverage available through the automobile insurance policy? ☐ Yes ☐ No
If yes, how much? $_____ Number of vehicles involved: _____

Is there other insurance coverage (other than listed above) available for the accident/injury? ☐ Yes ☐ No

If yes, please provide the following information-
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, please provide the following information:
Name: _____
Address: _____
Area Code and Phone Number: _____

Do you intend to retain an attorney? ☐ Yes ☐ No
If yes, please indicate the legal counsel's name, address, and phone number:
Name: _____
Address: _____
Area Code and Phone Number: _____

Is there anything else you would like us to know about this accident/injury? Please explain:
_____
_____
_____

Your phone number: (____) _____
Additional phone number where you may be reached: (____) _____

The above information is true to the best of my knowledge:

_____ 8/15/2016
Signature of injured person Date
(if injured person is less than 18 years of age then a parent or guardian must sign)

_____
Printed name of person signing above