Accident Questionnaire

Date:_____VHN Subscriber #: _____

Subscriber Name:_____Phone:_____

Address: _____

City/State/Zip:_____Date of Birth:_____

Email Address: _____

Date of Service:_____ Provider:_____

Section 1

1. Date of accident or injury:_____
2. Type of Accident (Please check):
   - ☐ Work (Complete section 2)
   - ☐ Automobile (Complete section 3)
   - ☐ Motorcycle (Complete section 3)
   - ☐ Other accident (Complete section 4)
3. Have you hired an attorney as a result of this accident?
   - ☐ Yes
   - ☐ No
4. Name, address, and phone number of your attorney (if applicable):
   _____
   _____
   _____
   _____

Volusia Health NETWORK

Section 2

Complete the following questions if this accident or injury is work related.

1. Have you filed a worker's compensation claim?
   - ☐ Yes
   - ☐ No
2. Has your employer or their worker's compensation insurance company accepted liability?
   - ☐ Yes
   - ☐ No
   - ☐ Pending
3. Worker's compensation insurance company:
   Case workers name: _____
   Phone number: _____
   Claim number:_____

Section 3

Complete the following questions if this accident or injury is related to an automobile accident or motorcycle accident.

1. Was the patient:
   - ☐ Driver
   - ☐ Passenger
   - ☐ Pedestrian
   - ☐ Other (Please explain and give specific information)

_____
_____
_____
_____

2. Did another person cause the accident?
   - ☐ Yes
   - ☐ No

3. Responsible party's Name:_____
   Address: _____
   _____
   Phone Number: _____

4. Responsible party's Insurance Company (including No-Fault Ins.):
   Name:_____
   Address: _____
   _____
   Phone Number: _____
   Policy number: _____

Section 4

Complete the following questions if this accident or injury is related to an "other" accident.

1. Specific location of accident (Name and Address):
   _____
   _____
   _____
   _____
2. Please describe in detail how the accident occurred:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

3. Did another person cause this accident?
   - ☐ Yes
   - ☐ No

4. Responsible party's Name:_____
   Address: _____
   _____
   Phone Number: _____

5. Responsible party's Insurance Company (including No-Fault Ins.):
   Name: _____
   Address: _____
   _____
   Phone Number: _____
   Policy number: _____

I certify to the best of my ability and knowledge that the above information is true and correct.

Print Name: _____
Signature: _____
Date: _____

Please forward this questionnaire to:

Volusia Health Network
P.O. Box 2814
Daytona Beach, FL. 32120
Att: Claims Department