



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):



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: _____

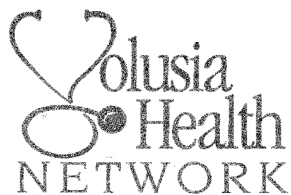
Policy number: _____

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**