Core Management Resource Group Incident Questionnaire

Dear Member

A claim was received for treatment or condition which has diagnoses that could be related to an accident or incident. To make sure proper benefits are applied, **Core Management Resource Group** requires an Accident - Incident Questionnaire form to be fully completed, signed, and returned. This will help determine if any other parties (such as auto insurance) are responsible for your injury or illness. We cannot proceed with the processing of your claim until the Accident - Incident Questionnaire form is fully completed, signed, and returned.

Next Steps

1. Complete the General Information section in the form to give us more details about your injury or condition.

2. Next, complete any other required sections based on your responses.

3. Sign and date the form

4. Return the completed Incident Questionnaire form within 30 days from the date of this letter.

5. You may also call customer service for help filling out the form.

If we don't hear from you

- Your claim(s) will be denied if you do not return the completed form within 30 days from the date of this letter.

- If your claim is denied, you may be responsible for some or all the costs of your care.

Send completed form via:

Fax: 478-750-1750

Email:
claims@secure.corehealthbenefits.com

Mail:
Core Management Resources Group
PO Box 90
Macon, GA 31202

Questions? Please Call
478-741-3521
888-741-3521
Monday through Friday
8 a.m. to 5 p.m. Eastern Time

When completing the form, use black or blue ink and print clearly and legibly. A decision will be made no later than 30 days after the Incident Questionnaire has been received. If the form is not sufficiently filled out or if additional information is required, you may be contacted.

FAILURE TO PROVIDE THIS INFORMATION WITHIN 30 DAYS MAY RESULT IN CLAIM DENIALS

Thank you for your assistance and for allowing us to serve you.

Patient Name: _____ Group Number: _____
Member ID: _____ Date of Service: _____
Claim Number: _____

Accident – Incident Questionnaire

****Failure to provide complete information to the questions below within 30 days may result in claim denial****

Was the injury or illness the result of:
☐ a motor vehicle accident (car, truck, motorcycle, ATV, etc.)
☐ a work-related accident
☐ another type of accident (slip and fall, sports injury, etc.)
☐ no accident

Date of injury or illness: _____

Where did the accident or injury occur (such as home, work, school, restaurant, on the way to work or school, etc.)? If known, please include address. _____

Briefly explain why you received treatment from this provider and include the body area(s) affected by this injury or illness:
_____
_____

If you checked "Motor Vehicle Accident" above, please complete this section.

Was the patient a: ☐ Driver ☐ Passenger ☐ Pedestrian Was another party at-fault for the accident? ☐ Yes ☐ No ☐ Undetermined
Type of vehicle(s) involved (check all that apply): ☐ Auto ☐ Motorcycle ☐ ATV ☐ Other (please specify): _____
Patient's auto insurance company: _____ Policy/Claim Number: _____
Name and Address of the other party involved in the accident: _____
Other Party's insurance company: _____Policy/Claim Number: _____
If a police report was filed, please include a copy when this questionnaire is returned to Core.

If you checked "Work-Related Accident" above, please complete this section.

Name and address of patient's employer at the time of injury: _____
_____
Have you already or do you plan to file a workers' compensation claim? ☐ Yes ☐ No
Name of workers' compensation carrier: _____ Claim #: _____
Has the employer or workers' compensation carrier accepted liability? ☐ Accepted ☐ Denied ☐ Undetermined
If Denied, do you intend to file an appeal? ☐ Yes ☐ No

If you checked "Another Type of Accident" above, please complete this section.

Is someone else responsible for your injury or illness? ☐ Yes ☐ No If yes, name and address of person responsible: _____
_____
Did the accident occur on someone else's property? ☐ Yes ☐ No
Does the person have insurance? ☐ Yes ☐ No If yes, name of insurance company: _____ Policy #: _____
Do you intend to file a claim against the responsible party or insurance company? ☐ Yes ☐ No

Attorney Information:

Have you, or do you intend to, hire an attorney to assist you with this case? ☐ Yes ☐ No
If yes, please provide the name, address and contact information for your attorney: _____
_____

Signature: _____ Date: _____
Printed Name: _____