



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

THIRD PARTY LIABILITY
P.O. BOX 8022
HARRISBURG, PENNSYLVANIA 17105-8022

MEDICAL SERVICES QUESTIONNAIRE

PERSON RECEIVING SERVICES	
CASE NUMBER	SERVICE DATE
PROVIDER NAME	

Marque aquí si usted necesita esta forma en español Devuelva la forma en el sobre timbrado adiuño.

DATE	CIS NUMBER

Our records show Medical Assistance or an HMO paid bills for services to _____
This form **MUST** be answered completely on both sides to determine whether an insurance company or another person should have paid the bill. Please return the completed form in the stamped, self-addressed envelope provided. The form must be returned within 15 days of the date you received this form.

PLEASE ANSWER THE SECTION(S) THAT RELATE TO THE MEDICAL SERVICES

SECTION 1 - WERE the SERVICES PROVIDED as the RESULT of a MOTOR VEHICLE ACCIDENT (MVA)?

Accident Date _____ List Injuries _____
Was Injured Person (Check One) Driver Passenger Pedestrian
Was Injured Person In/On (Check One) Car/Truck Motorcycle Bus Bicycle Other _____
At the Time of the Accident, did You or Any Relative in Your Household Have a Registered Vehicle?
 YES NO If the Answer is YES, Please Complete the Following Information.

Name and Address of Insurance Company _____ Telephone # () _____
Policyholder _____ Policy # _____ Claim # _____

If Injured Person Was a Passenger or Pedestrian, Complete the Following Information.

Name and Address of Driver _____ Telephone # () _____
Name and Address of Vehicle Owner's Insurance Company _____ Telephone # () _____
Policyholder _____ Policy # _____ Claim # _____

Have you filed an Insurance Claim? (Check One) YES NO

Do You Have An Attorney? (Check One) YES NO

Attorney's Name and Address _____ Telephone # () _____

What Police Department Responded to the Accident? _____
Please send a copy of the Police Report.

Description of Accident (Location, Number of Vehicles Involved, etc.)

(PLEASE TURN TO THE OTHER SIDE)

SECTION 2 - WERE the SERVICES PROVIDED as the RESULT of a WORK INJURY?

Date of Injury _____ List Injuries _____
Name of Employer _____ Telephone # () _____
Have you filed a Worker's Compensation Claim? (Check One) ___ YES ___ NO
If "YES" Give Claim Number _____
Name and Address of Insurance Company _____
_____ Telephone # () _____
Do You Have An Attorney? (Check One) ___ YES ___ NO
Attorney's Name and Address _____
_____ Telephone # () _____

SECTION 3 - WERE the SERVICES PROVIDED as the RESULT of a FALL or BURN or MEDICAL MALPRACTICE (Circle 1)

Date of Incident _____ List Injuries _____
_____ Telephone # () _____
Do You Have An Attorney? (Check One) ___ YES ___ NO
Attorney's Name and Address _____
_____ Telephone # () _____
Have you filed an Insurance Claim? (Check One) ___ YES ___ NO
If "YES" Give Claim Number _____
Name and Address of Insurance Company _____
_____ Telephone # () _____

Description of incident:

SECTION 4 - WERE the SERVICES PROVIDED as the RESULT of an ASSAULT?

Date of Incident _____ List Injuries _____
Defendant's Name _____ Docket or Court Case # _____
Do You Have An Attorney/District Attorney? (Check One) ___ YES ___ NO
Attorney/District Attorney's Name and Address _____
_____ Telephone # () _____

Description of incident:

SECTION 5 - WERE the SERVICES PROVIDED as the RESULT of an ILLNESS or CHRONIC CONDITION?

Have you filed an Insurance Claim? (Check One) ___ YES ___ NO
If "YES" Give Claim Number _____
Name and Address of Insurance Company _____
_____ Telephone # () _____

Explanation:

THIS SECTION MUST BE COMPLETED

Name of Person Completing This Form _____ Date _____
Telephone # Where You Can Be Reached: Home () _____ Work () _____