Priority Health

Member injury questionnaire

Complete this questionnaire to help determine how your care will be paid for. If you need more space for your answers, use the back of this questionnaire.

Name_____ Priority Health member ID_____

1. What medical condition do you have?_____

2. Are the medical services you are receiving for treatment of an injury? ☐ Yes ☐ No
   If "yes":

   Date the injury occurred____/____/____ Place the injury occurred_____

   How did the injury happen?_____

   Attach (or include on the back) the names and address of all parties involved. ☐ Attached ☐ Included on back

3. Is this condition or injury covered by other insurance? ☐ Yes ☐ No
   If "yes," what type of insurance?

   ☐ Homeowner ☐ Worker's compensation ☐ Auto ☐ Business owner ☐ Other

   Policy number_____ Claim number_____

   Policyholder name and address_____

   Insurance company name and address_____

   Agent name, address and phone number_____

4. Have you hired an attorney? ☐ Yes ☐ No

   If "yes," list the attorney's name, address and telephone number_____

5. Have you had any other health insurance while covered by Priority Health? ☐ Yes ☐ No

   Name of the other insurance company_____

   Name of the person insured by the other insurance_____

   Policy and/or group number_____ Policy effective date____/____/____

Member's signature_____ Date____/____/____

Below for health care provider use only.

Diagnosis being billed for this visit_____

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