VERMONT

# Insurance / Accident Questionnaire

Department of Vermont Health Access (DVHA)
ATTN: Accident Response
HP Enterprise Services
PO Box 1645
Williston, VT 05495-9983

Accident Questionnaire Team
**Phone:** 802-879-4450 Press Option 5
**OR** 1-800-925-1706 Press Option 5
**Fax:** 802-857-2992

As a Medicaid or VHAP beneficiary, medical care has been paid for you or your dependent(s), resulting from an accident, injury, illness or condition. There may be other insurance (health, auto, injury insurance) or some other source which could pay for this care. Please fill in the boxes, answer all four questions, sign, and return this questionnaire to us within **ten (10) days** in the enclosed stamped / addressed envelope.

If you have questions, please call us directly at 1-800-925-1706, Option 5.

**Failure to complete and return the questionnaire *may result* in closure of your Medicaid/VHAP coverage or denial of a future Medicaid/VHAP application**.

**Patient's Name:** _____ (Please Print) **Date of Birth**: _____

**Medicaid I.D.#:** _____ **Soc.Sec.#:** _____ **Date of Incident:** _____

**Case #:** _____ (from cover letter) **Check only one that applies:** ☐ accident ☐ injury ☐ illness or condition

**Explain what happened and list all injuries:** _____

_____

**QUESTION 1 - Was the patient covered by any insurance such as cancer, accident, disability, indemnity, group or individual health insurance *other than* Medicaid, VHAP, or Medicare on the date of the accident, injury, illness or condition?** ☐ **NO** ☐ **YES** (If yes, complete the following)

Name and address of insurance company (ies): _____

_____

Policy number(s): _____ Policy holder(s): _____

**QUESTION 2 - Was medical care related to an automobile accident that caused injury?** ☐ **NO** ☐ **YES**
**(If YES, complete the following)**

Patient was the: ☐ driver ☐ passenger ☐ pedestrian

Vehicle was a: ☐ auto ☐ motorcycle ☐ bus ☐ other – please specify: _____ ☐ N/A

**Were you at fault?** ☐ **NO** ☐ **YES** **Was another person at fault?** ☐ **NO** ☐ **YES**

**Name & Address: *"Your"* insurance company:**

_____

_____

Policy #: _____

Policy Holder: _____

**Name & Address: "*Other Person's*" insurance company:**

_____

_____

Policy #: _____

Policy Holder: _____

Name and address of all vehicle drivers: _____

_____

Name of Police Department that investigated: _____

**(Turn over, please.)**

**QUESTION 3 - Was medical care related to anything other than a motor vehicle accident?** ☐ **NO** ☐ **YES**
**(If YES, answer questions 3A-3C)**

**3A)** Was this related to a **Worker's Comp (injury on the job)** claim? ☐ NO ☐ YES **(If yes, complete the following)**

Employer's name: _____

Address: _____

_____

Telephone Number: _____

Worker's Comp Company: _____

_____

Case or Account #: _____

Telephone Number: _____

**3B) If patient's injury or accident was caused by another person or occurred on someone else's property (store, school, neighbor's home, relative's home, business, etc.), did they have insurance (car, homeowner's or other liability insurance)?** ☐ **NO** ☐ **YES** **(If yes, complete the following)**

Name and address where injury occurred: _____

_____

Name and address of insurance company: _____

_____ Case Number: _____

**3C) Was this an assault?** ☐ **NO** ☐ **YES** **(If yes, please describe)** _____

_____

**QUESTION 4 - Has an attorney been retained as a result of this accident/injury/illness/condition?** ☐ **NO** ☐ **YES**
**(If yes, complete the following)**

Attorney's name, address, and phone number: _____

_____

Was there a settlement? ☐ **NO** ☐ **YES** **(If Yes)** Amount: $_____ Date: _____

When Medicaid has paid or will pay for any medical care required as a result of an accident/injury/illness/condition caused by another person or party, ***or*** if the payment for this medical care is another's legal responsibility, the DVHA can assert the rights and claims of the Medicaid beneficiary against the responsible person or party, to the extent of the medical payments made by, or to be made by the DVHA. In other words, the state has the right to collect any money from a third party involved in the personal injury or related illness/condition in order to be reimbursed for the cost of your care.

You must cooperate with the DVHA to secure and protect these rights and claims. **You shall not settle or compromise these rights or claims without prior written consent from the DVHA**. You also agree that the DVHA may take legal action to protect or recover these claims.

_____ _____
Signature of Beneficiary, Parent - if beneficiary is a minor, or Legal Guardian Date

_____ _____
If signed by parent or legal guardian, please print your name Daytime telephone number

Additional Comments (Attach additional sheets if necessary): _____

_____

_____

(You should submit any additional information, if and when it becomes known.)