DVHA 248
R 11/2011

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): ___________________________________

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