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 espanol Devuelva la forma en el sobre timbrado adiuñto.

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 ( ) _____