

### THIRD PARTY LIABILITY QUESTIONNAIRE

Dear Patient:

In order to process your insurance claim we ask that you answer the following questions: (The insurance company will not pay on an accident or injury until proof has been shown of a third party liability.)

1. Is your medical problem the result of an injury or accident? YES / NO
2. If your answer is **NO**, please sign the form and return it to the reception desk.
3. If your answer is **YES**, please continue.
4. Describe **how**, **when**, and **where** your accident or injury occurred: \_\_\_\_\_  
\_\_\_\_\_

5. Is your accident or injury Auto related? YES / NO If YES, complete the following.

Will you be filing /seeking reimbursement from your/another Auto Insurance Company? YES / NO

Automobile insurance coverage: \_\_\_\_\_ Claim#: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Phone Number of Insurance Company: \_\_\_\_\_

Name, address, and telephone number of the driver cited or responsible for the accident: \_\_\_\_\_  
\_\_\_\_\_

6. Did the accident or injuries occur at your home? YES / NO

Will you be filing/seeking reimbursement from your/another Home Owners Insurance Company? Yes / No

Name of your Homeowners Insurance Company, address, and phone number: \_\_\_\_\_  
\_\_\_\_\_

7. Did the injury happen at another location? Yes / NO Please give the Name, Address, and Phone Number:  
\_\_\_\_\_

Will you be filing/seeking reimbursement from another Insurance Company? Yes / No

8. Have you contacted an attorney? YES / NO If YES, please give us the Name, Address, and Phone number of your attorney: \_\_\_\_\_  
\_\_\_\_\_

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**Signature**

**Date**