

# Accident/Injury Questionnaire

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)  
Benefit Plans Office - 1419 Hampton Avenue, Suite 100, St. Louis, MO 63139



## Please Print Your Information

We recently received a claim for the patient listed below that may be the result of an accident or injury. Please complete the form and return it to the Benefit Plans Office at the above address.

### Patient Information

Claim Number:

Patient Name

Patient Date of Birth

### What is the Patient's relationship to the Member?

- ☐ I am the Member ☐ I am the Member's Spouse ☐ I am the Member's Dependent

Member ID:

Member Name:

### Accident/Injury Information

1. Did the accident/injury occur while the Patient was at work? ☐ Yes ☐ No
2. **When** did the accident/injury occur? Date of Accident/Injury(MM/DD/YYYY): \_\_\_\_\_ Approximate Time of Day: \_\_\_\_\_
3. **Where** did the accident/injury occur? Location (Address, City, State, Zip): \_\_\_\_\_
4. Did the accident occur on public or private property? ☐ Public ☐ Private
5. Who is the property owner? Name, Address (if different than #3) and Phone Number of Property Owner: \_\_\_\_\_
6. How did the accident/injury occur? Please provide as much detail as possible (i.e., motor vehicle accident, playing softball, etc.):  
\_\_\_\_\_  
\_\_\_\_\_
7. If the accident/injury is related to a motor vehicle, utility vehicle (UTV), all-terrain vehicle (ATV) or golf cart accident, please answer the following:
  - a. Were any other vehicles involved? ☐ Yes ☐ No
  - b. Was the patient the: ☐ Driver ☐ Passenger
  - c. Was a police report filed? ☐ Yes ☐ No
8. Is the patient covered under **any other plan** for this injury? ☐ Yes ☐ No Provide information below:  
\_\_\_\_\_  
\_\_\_\_\_

**Accident details are required to determine if claims are payable by the Plan.** The Plan has subrogation provisions that require full disclosure of all third party liability accidents and injuries. If the injury is a result of a third party, the appropriate paperwork will be sent to you for completion before claims can be processed. For consideration of claims, it is very important to submit the information promptly. **Claims filed or information provided over 365 days from the date of the accident will be denied.**

### Patient Signature (signature of Parent if Patient is a minor up to age 18)

Signature	Relation to Patient	Date	Phone Number
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If you have any questions, please contact the Carpenters' Member Service Department:

Phone (local):	314.644.4802	Fax:	314.678.1110
(toll-free):	877.232.3863	Email:	benefits@carpdc.org