



Insurance/Accident Questionnaire

Office of Vermont Health Access (OVHA)
ATTN: Accident Response
EDS an HP company
PO Box 1645
Williston, VT 05495-9983

Rebecca Brown - Third Party Liability Unit
Phone: 802-879-4450 Press Option 5 **OR** 1-800-925-1706 Press Option 5
Fax: 802-878-3440

OVHA has paid for medical care for you or your dependent, as a Medicaid or VHAP beneficiary, related to an accident/injury/illness/condition. There may be other health insurance or some other source which could pay for this care. Please fill in the box, answer all four questions, sign, and return it to us within ten (10) days in the enclosed stamped, addressed envelope. **If you do not complete and return the questionnaire, your Medicaid/VHAP application may be denied or your benefits may end.** If you have questions, please call us directly at 1-800-925-1706, Option 5.

Patient's Name: _____	Medicaid ID/SS#: _____
Please Print	
Head of Household Name and SS#: _____	
Date of accident/injury/illness/condition: _____	Case #: _____ (from cover letter)
Check only the one that applies, and then explain below how this occurred: <input type="checkbox"/> injury <input type="checkbox"/> accident <input type="checkbox"/> illness or condition	

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/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 all of the following)

Was the patient a: driver passenger pedestrian
Vehicle patient was in: auto motorcycle bus other – please specify: _____ N/A
Other Vehicle: auto motorcycle bus other – please specify: _____ N/A

Where did the accident happen? _____

Name and address of insurance company #1: _____ _____	Name and address of insurance company #2: _____ _____
Policy #: _____	Policy #: _____
Policy holder: _____	Policy holder: _____

Name and address of all vehicle drivers: _____

Name of police department that investigated: _____

QUESTION 3 - Was medical care related to another type of accident/injury/illness/condition?

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: _____

Worker's Comp Company: _____

Address: _____

Case or Account #: _____

Telephone Number: _____

Telephone Number: _____

3B) If 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? _____ 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 OVHA 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 OVHA. 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 OVHA to secure and protect these rights and claims. You shall not settle or compromise these rights or claims without prior written consent from the OVHA. You also agree that the OVHA 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 additional information when it becomes known)