Third Party Liability Questionnaire

Name: _____ DOB: _____ SSN: _____

Date of injury: _____ Doctor: _____

How specifically, did injury occur?_____

WORKMANS COMP

Employer: _____ Employer phone#: _____

Workers Comp Carrier: _____ Claim Address: _____

Adjuster: _____ Phone#: _____ Fax#:_____

Claim#: _____ Authorization#:_____

Automobile Related: ☐ (Fill Auto. Claim section below) Attorney Involved: ☐ (Fill Attorney Info. section below)

PERSONAL INJURY

Liability carrier:_____ Claim#_____

Claim Address: _____

Adjuster: _____ Phone#: _____ Fax#:_____

Automobile Related: ☐ (Fill Auto. Claim section below) Attorney Involved: ☐ (Fill Attorney Info. section below)

AUTOMOBILE CLAIM

Patient auto carrier:_____ Claim#: _____

Claim Address: _____

Adjuster: _____ Phone#: _____ Fax#:_____

Medical Payments (MedPay) coverage available: $_____

Other party's auto carrier_____ Claim#: _____

Claim Address: _____

Adjuster: _____ Phone#: _____ Fax#:_____

ATTORNEY INFORMATION

Attorney: _____ Attorney file#:_____

Attorney address: _____

Attorney Phone#: _____ Attorney Fax#_____

Preferred Method of Communication - E-Mail: _____ Fax: ☐ Certified Mail: ☐