Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Florida Health Care Plans, Inc.
Accident or Injury Questionnaire

Date: _____ FHCP # (Found on ID card): _____

Medical Provider: _____

Subscriber Name: _____ Phone: _____
Address: _____
City/State/Zip: _____ Date of Birth: _____
Email Address: _____

Section 1

1. Date of accident or injury: _____

2. Type of accident (Please check):
   - ☐ Home (Your Residence) *(Complete Section 2)*
   - ☐ Work *(Complete section 3)*
   - ☐ Automobile *(Complete section 4)*
   - ☐ Motorcycle *(Complete section 4)*
   - ☐ Other Accident *(Complete section 5)*

3. Have you hired an attorney as a result of this accident?
   - ☐ Yes
   - ☐ No

4. Name, address, and phone number of your attorney (if applicable):
   _____
   _____
   _____

Section 2 (Home)

Complete the following questions if this accident of injury occurred at your home (residence)

1. Please describe in detail how this accident happened:
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Section 3 (Work)

Complete the following questions if this accident or injury is work related.

1. Please describe in detail how this accident happened:
   _____
   _____
   _____
   _____
   _____

2. Have you filed a worker's compensation claim?
   - ☐ Yes
   - ☐ No

3. Has your employer or their worker's compensation insurance company accepted liability?
   - ☐ Yes
   - ☐ No
   - ☐ Pending

4. Name, address, and phone number of employer:
   _____
   _____
   _____

5. Worker's compensation insurance company name, policy number, address, phone number, and case worker's name:
   _____
   _____
   _____

Section 4 (Automobile or Motorcycle)

Complete the following questions if this accident or injury is related to an automobile accident or motorcycle accident.

1. Was the patient:
   - ☐ Driver
   - ☐ Passenger
   - ☐ Pedestrian
   - ☐ Other (please explain and give specific information) _____
   _____

2. Did another person cause this accident?
   - ☐ Yes
   - ☐ No

3. Responsible party's name, address, and phone number:

_____
_____
_____

4. Responsible party's insurance company name, policy number, address, and phone number (including no-fault insurance):

_____
_____
_____

5. If a motorcycle accident/incident, do you have a motorcycle policy with PIP coverage?
   - ☐ Yes
   - ☐ No

Section 5 (Other)

Complete the following questions if this accident or injury is related to an "other" accident.

1. Specific location of accident (name and address):

_____
_____
_____

2. Please describe in detail how this accident happened:

_____
_____
_____
_____
_____

3. Did another person cause this accident?
   - ☐ Yes
   - ☐ No

4. Responsible party's name, address, and phone number:

_____
_____
_____

5. Responsible party's insurance company name, policy number, address, and phone number (including no-fault insurance):

_____
_____
_____

Please return this form in the enclosed postage paid envelope to:

Florida Health Care Plans
Attn: COB Department
P.O. Box 9910
Daytona Beach, FL 32120
Or
Fax: (386) 481-5071

Any questions please call:
(386) 615-5062 or toll-free (800) 852-9824, ext. 5062

I certify to the best of my ability and knowledge that the above information is true and correct.

Printed Name: _____

Signature: _____

Date: _____