MACoHCT

MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST

PO Box 1966
Missoula, MT 59806-1966
1-888-883-3233

Date: ____________________

Claim Number if known: ___________________________
Name of Treating Physician: ________________________
Date of Service: ___________________
Injured Person: ____________________
Name of Employer/Plan Sponsor: _______________________________
Participant Name: __________________________________

Dear ______________________,

We have received the above claim indicating a possible accident or injury. Please complete the following questionnaire and return it to the address above. Pursuant to the claims processing policy adopted by the plan, we must receive this information within 45 days of the date of this letter or the claim will be denied. Thank you in advance for your prompt attention to this request.

Was the above date-of-service the result of an accident/injury? ____Yes ____No
If no, please explain:

____
____
____
____

***If yes, please list the date of the accident/injury: _______________________________________

Please describe how the accident/injury occurred:

____
____
____
____

Please describe where the accident/injury occurred:

____
____
____

Please describe what body parts were involved in the accident/injury:

____
____
____

Did the accident/injury happen while you were working? ____Yes ____No
If yes, has the employer been notified? ____Yes ____No
If yes, please list the date the employer was notified ____

If the accident or injury happened while you were working, please describe the circumstances of the accident or injury:

____
____
____
____

Claim Number if known: ______________________________
Name of Treating Physician: ___________________________
Date of Service: ________________
Injured Person: __________________________________
Name of Employer/Plan Sponsor: _________________________________

Was the accident/injury the result of a motor vehicle accident? _____Yes _____No
Were you the _____Driver _____Passenger _____Pedestrian
Driver's Name: ____________________________
Policyholder's name if not the same as driver:_____________________________________
Auto Insurance Company_______________________________ Phone #: (_____)________________
Claim Number: _______________________________
Was a traffic citation issued? _____Yes _____No If yes, to whom?____________________________
Is there medical coverage available through the automobile insurance policy? _____Yes _____No
If yes, How much? $_______________ Number of vehicles involved: _____________

Is there other insurance coverage (other than listed above) available for the accident/injury? __Yes __No
If yes, please provide the name, address, and telephone number of the other insurance company:

Name of other insurance company ____

Address ____

City, State, Zip ____
Area code and phone number (______)____

Is another party liable for the accident/injury? _____Yes _____No
If yes, please provide their name, address, and telephone number:
Name____
Address____
Area code and phone number____

Do you intend to retain an attorney? _____Yes _____No
If yes, please indicate the legal counsel's name, address, and phone number
Name of legal counsel____
Address____
Area code and phone number ____

Is there anything else you would like us to know about this accident/injury? Please explain:
____
____

The above information is true to the best of my knowledge

____ _____ ________________
Signature of injured person (if injured person is less than 18 years of age then a parent or guardian must sign) Date

____
Printed name of person signing above