DELTA
HEALTH SYSTEMS
ADMINISTRATION SERVICES

Claim# :
Health Care ID # :

Questionnaire

If this accident/illness is due to any fault of another party, please return this completed form with the signed Agreement to Reimburse. If there is no third party involved, please complete only 1 – 7.

1. Patient Name	
2. Relationship to Participant	
3. Daytime Phone Number of Injured	
4. Date of Accident or Onset of Illness	
5. Where did the accident or onset of illness occur?	
6. If due to an accident, please provide details of how the accident occurred.	
7. Was there another party involved? If so, please provide any contact information you may have for this third party.	

Work-Related Questions	
8. At the time of the accident or onset of illness, were you: ▪ at work, ▪ traveling for work, or ▪ at a required work-sponsored event?	Yes No **If yes**, have you filed a Workers Compensation Claim?
	If yes, please provide: Claim/Appeal #: Status: Open Closed
	What is the name, address and phone number of the workers comp carrier?

Accident-Related Questions	
9. Were you wearing any required safety equipment, such as a seatbelt or helmet?	Yes No Comment:
10. Is this injury/illness due to an auto accident?	Yes No Comment:

Legal/Claims Information	
11. Did you, or are you going to, file a claim against any auto, or homeowner policy?	Yes No **If yes**, please indicate who the claim or action is against (name of policy holder).
	Name, address and phone number of the insurance company:
	Claim or policy number
12. Do you have any medical pay coverage on your own auto or homeowners policy?	Yes No **If yes**, please provide the carrier's name, address, phone number and your policy number.
13. Have you contacted an attorney?	Yes No **If yes**, please provide your attorney(s) name, address and phone number.
14. If a lawsuit has been filed, what is the status of the case?	Please provide details and a copy of any settlement amount or judgment award.

I hereby certify that the above information is true and correct:

_____ _____

Signature of Plan Participant Date

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Agreement to Reimburse

IN CONSIDERATION of payment of my/our medical bills for injuries arising from my/our accident, and pursuant to the terms, conditions, and exclusions of my Health Plan, I agree to reimburse my Health Plan for all sums paid by the Plan for the treatment of injuries I or my dependent(s) sustained in the accident described on the previous page. I agree to allow Delta Health Systems to place a lien against any and all sums recovered by means of settlement, verdict, judgment, or otherwise on my/our claim or lawsuit against the parties causing said accident and my/our injuries. Reimbursement to Delta Health Systems shall be paid from said sums recovered by such settlement, verdict, or judgment.

I further authorize and direct my attorney to comply with the terms of this Agreement to Reimburse and allow a lien, and to pay Delta Health Systems out of my attorney's trust account the full amount of said lien from any and all sums received by settlement, verdict, or judgment of my claim or lawsuit.

I further agree that if my attorney or I breach this Agreement and an action is brought to collect the amount of said lien, I will pay reasonable attorney's fees and costs incurred in said action.

Participant Confirmation

Date: _____ _____
Signature

_____
Print or Type Name

Attorney Confirmation

I have explained to my client(s) the terms of the Agreement to Reimburse. I agree to comply with the wishes of my client(s) expressed in said Agreement.

Date: _____ _____
Signature

_____
Print or Type Name

Phone: (800) 422-6099 * Fax: (209) 474-5407 * P.O. Box 80 Stockton, CA 95201-3080