PO Box 22557
Charleston, SC 29413
Phone: 800.815.3314
Fax: 843-722.2866
Web:www.tccba.com

ACCIDENT QUESTIONNAIRE

TCC Benefits Administrator℠

Subscriber: _____ Provider: _____
Address: _____ Date of Service: _____
Address: _____ Group Number: _____
Patient: _____ Claim Number: _____
Identification No.: _____ Claim Amount: _____

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information we may have to deny your claims. **If you have previously completed a form for this accident, please check here ☐ and update.**

Was the injury of illness: ☐ **Auto/Motorcycle Accident** ☐ **Work Related** ☐ **Other Accident** ☐ **No Accident**
Date of the injury or illness: _____ City/County and State of Injury: _____
Describe the injury or illness and how it happened: _____
_____
Names of other family members injured: _____

If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:

Did another person cause this accident? ☐ Yes / ☐ No
If yes, name and address of person causing injury: _____
Insurance Company of person causing injury: _____ Policy/Claim #: _____
Address and Phone #: _____ Adjuster's Name: _____
If auto or motorcycle related, was the patient wearing a seatbelt? ☐ Yes / ☐ No a helmet? ☐ Yes / ☐ No
If auto or motorcycle related, was the patient the ☐ driver or a ☐ passenger?
Auto Insurance Company of Patient: _____ Policy/Claim #: _____
Address and Phone #: _____ Adjuster's Name: _____
Name, address and telephone number of your attorney (if applicable): _____
_____

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: _____
Have you filed a Workers' Compensation claim? ☐ Yes / ☐ No
If yes, name of Workers' Compensation carrier: _____
Policy/Claim #: _____ Adjuster's Name: _____
Address and Phone #: _____
Has the employer or the Workers' Compensation carrier accepted or denied liability? ☐ ACCEPTED / ☐ DENIED
Name, address and telephone number of your attorney (if applicable): _____
_____

I agree that the above information is correct, and I will not settle a claim before contacting TCC Benefits Administrator.

_____
Signature Date Telephone Number

Please return this form to: TCC Benefits Administrator, P.O. Box 22557, Charleston, SC 29413