

OKLAHOMA HEALTH CARE AUTHORITY
4545 N. Lincoln Blvd., Suite 124
LINCOLN PLAZA OFFICE BUILDING
Oklahoma City, Ok. 73105
(405) 522-7451 (800) 268-5261

HEALTH INSURANCE AND INJURY/ACCIDENT QUESTIONNAIRE

Date _____
Recipient ID # _____
Date of Service: Diagnosis: _____

The Oklahoma Health Care Authority has paid for medical care you received on the above date. Our records show the treatment was due to an injury/accident. The following information is needed to determine if another source should pay your medical bill(s). Read all sides of this form and **answer only those sections that apply to the injury listed at the top of this form. THIS FORM MUST BE RETURNED, FAILURE TO DO SO MAY RESULT IN TERMINATION OF YOUR MEDICAID BENEFITS.** Please sign this form and return to us within 10 days in the enclosed self addressed envelope. No postage is necessary.

IF THE ABOVE DIAGNOSIS IS RELATED TO AN **INJURY**, COMPLETE **SECTION "A"** THEN, GO TO THE NEXT SECTION THAT PERTAINS TO THAT INJURY. IF THE ABOVE DIAGNOSIS IS RELATED TO AN **ILLNESS** ONLY, PLEASE EXPLAIN HOW THE ILLNESS RELATES TO THE ABOVE DIAGNOSIS _____
THEN COMPLETE **SECTION "A"** AND PROCEED TO **SECTION "K"(PART 2).**

SECTION A (This section must be completed)

Are you covered by any type of group or individual HEALTH INSURANCE COVERAGE other than MEDICAID or MEDICARE? (examples are: Cancer Policy, Medicare Supplement, Champus, Etc.) **YES** ___ **NO** ___ If yes, please provide the following information. Name/Address of insurance company _____
Policy # _____ Group # _____ Policyholders Name/Address _____

Social Security # of Policyholder _____ Effective Date of Policy _____ Date of injury _____
If policy is through an employer, provide the Employers name/address/phone # _____

SECTION B ON-THE-JOB-INJURY

Date of injury _____ Employers name/address _____
Work Comp Court Case # _____ Your Social Security # _____ Date of Birth _____ How did this injury occur? _____

_____ I authorize the Oklahoma Health Care Authority to access the above information with my social security # (SIGNATURE OF INJURED PARTY)

GO TO SECTION K (Part 1 & 2)

SECTION C

ASSAULT

What is the name of the person who assaulted you? _____ Was the injury a result of a BEATING _____ STABBING _____ SHOOTING _____ SEXUAL ASSAULT _____ OTHER _____ Did you file charges against this person? YES ___ NO ___. If yes, where did you file charges (Police/Sheriff Dept)? _____. If filed with the District Attorney, Name of the County where charges were filed _____. What is the Court Case #? _____ Date of Injury _____

GO TO SECTION K (Part 1 & 2)

SECTION D **MOTORIZED VEHICLE ACCIDENT(CAR, 3-WHEELER, BOAT, MOTORCYCLE)**

Type of vehicle _____ Were you the driver _____ passenger _____ pedestrian _____ If you were not the driver, list the driver's name here _____ List other people involved in the accident (including other vehicle) _____

Where did the accident happen (Street Location, City, State) _____

Did the police investigate and file a report? YES ___ NO ___. If yes, which law enforcement agency completed the report (highway patrol, sheriff, police). List name/address of Agency _____ If you have a copy of the accident report, please attach. Please provide the name of **your** Insurance Company. _____

Policy # _____, Claim # _____ **Other drivers** Insurance

Company Name _____ Policy # _____ Claim # _____

Date of injury _____

GO TO SECTION K (Part 1 & 2)

SECTION E

INJURY AT MY SCHOOL

Name/address of school _____ Do you have student accident insurance? YES ___ NO ___ If yes, give name of Insurance Company _____

Policy # _____ Claim # _____ Date of Injury _____

How did the injury occur? _____ **GO TO SECTION K (Part 1 & 2)**

SECTION F

INJURY AT

STORE/OTHER PUBLIC PLACE

(department store, grocery store park, daycare, nursing home, etc.)

Give name/address of the store/public place where injury occurred _____

Did you report the incident to someone? YES ___ NO ___. If yes, who did you report it to? _____ Did they complete a report of the incident? YES ___ NO ___. Provide the

Policy # _____ Claim # _____ Who is handling your claim? (Name/Phone #) _____ How did this injury occur? _____

Date of _____

Injury _____

GO TO SECTION K (Part 1 & 2)

***** **SECTION G**

INJURY AT A

NEIGHBORS OR RELATIVES HOME Name/address/phone number where the injury occurred _____

How did the injury occur? _____ Do they have Home Owners insurance? YES ___ NO ___ If yes, Name of Insurance Company _____

Policy # _____ Claim # _____ Agents _____

Name _____ Phone # _____ Date of Injury _____

GO TO SECTION K (Part 1 & 2)

SECTION H

FAULTY PRODUCT INJURY

Name of product _____ Name of Company _____ Name of insurance company _____
Policy # _____ Claim # _____ Adjusters Name _____
Phone Number _____ How did the injury occur? _____ Date of _____

Injury _____ **GO TO SECTION K (Part 1 & 2)**

SECTION I

MEDICAL MAL-PRACTICE INJURY

Name/address/phone number of medical provider (physician, hospital, etc.) _____

Who is handling your claim?(Name/phone #) _____ How did the injury occur? _____ Date of _____

Injury _____ **GO TO SECTION K (Part 1 & 2)**

SECTION J

INJURY AT MY HOME

How did the injury occur? _____ Do you have any insurance which would cover this injury? YES___ NO___ If yes, Name of Insurance Company _____ Phone # _____

Policy # _____ Claim # _____ Date of _____
Injury _____ **GO TO SECTION K (Part 1 & 2)**

SECTION K (Part 1)

What injuries did you incur as a result of the above incident/accident?

Have you retained an Attorney due to the above injury? YES___NO___ If yes, provide the Name/Address/Phone Number of your Attorney. _____ Has a lawsuit been filed? YES___NO___
Has a settlement been reached? YES___NO___ If yes, attach a copy of the settlement sheet, which shows how much and who was paid.

SECTION K (Part 2) I authorize any holder of medical and other information about me to release information needed for this or a related Medicaid Claim to the Oklahoma Health Care Authority and I further authorize the release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the OHCA all claims against third parties, including tort-feasors and insurance companies who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid. I permit a copy of this authorization to be used in place of the original. **I FURTHER UNDERSTAND THAT FAILURE TO PROVIDE THE ABOVE INFORMATION MAY RESULT IN TERMINATION OF MY MEDICAID BENEFITS.**

Recipient Signature (or guardian, if a minor)

Phone # where you can be reached

Date

