Eliance Health Solutions℠
Powered by Penn Medicine

Please return completed form to:
Eliance Administrators, Attn: Customer Service
P.O. Box 7046, Lancaster, PA 17604-7046
Fax: 717-553-1125
Questions? Call 717-553-1124

Incident Questionnaire

Section A. SUBSCRIBER INFORMATION		
Subscriber (employee) Name:	Group#:	Family ID #:
Subscriber's Employer:	Date of Birth:	Daytime Phone#:
Patient's Name:	Patient's Date of Birth:	
Section B. GENERAL INFORMATION		
Is this claim due to an incident/accident? ☐ Yes ☐ No **If no, then skip to section G.**	Date of incident:	
Briefly describe the incident, Including the location/address:		
Section C. PLEASE COMPLETE FOR AN ON THE JOB INJURY OR ILLNESS *If a Workers' Compensation claim has been filed and denied, a copy of the denial letter must be submitted to Eliance Administrators.*		
Name and address of patient's employer at the time of the incident:		
Has a Workers' Compensation claim been filed? ☐ Yes ☐ No	Original date of incident:	
Has the Workers' Compensation carrier accepted or denied liability? ☐ Accepted ☐ Denied		
Section D. PLEASE COMPLETE FOR A MOTOR VEHICLE ACCIDENT *A copy of the police report must be submitted to Eliance Administrators. If there is no police report, provide reason why.*		
The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other (explain):		
The vehicle was a: ☐ Automobile ☐ Motorcycle ☐ ATV ☐ Other (explain):		
Did another person cause the accident? If yes, please provide name and address of person.		
List any other member(s) of the patient's family injured in this accident:		
Please provide vehicle insurance for all parties involved in accident:		

Section E. PLEASE COMPLETE FOR OTHER TYPE OF INCIDENT

A copy of the police report must be submitted to Eliance Administrators, if applicable.

Did this incident occur on someone else's property?	Was this incident the fault of another person or business?
☐ Yes ☐ No	☐ Yes ☐ No

Has the patient filed an insurance claim with the at-fault party or will they be filing a claim? ☐ Yes ☐ No

If yes, provide name and address of the at-fault party:

Name, address and policy number of at-fault party's insurance carrier:

List any other member(s) of the patient's family involved in this incident:

Section F. PLEASE COMPLETE FOR ATTORNEY INFORMATION

Has the patient retained an attorney regarding this incident? ☐ Yes ☐ No

If yes, provide name, address and phone number of the attorney:

Section G. PATIENT SIGNATURE (or Subscriber for minor children or a personal representative)

I understand that if I (or my dependent) has been in an accident or injured by another party, or have a work-related accident or illness, the benefits of my health plan will be made available subject to its terms, conditions and exclusions.

I understand that my participation in my health plan means that I have agreed to the plan's Subrogation and Reimbursement Provision. This means that if my plan provides any benefits for injuries caused by another party who may be liable for those injuries, my health plan may be entitled to recover those costs from any settlement I receive from the at-fault party or that my health plan excludes benefits payable from another source. I understand that I need to contact my health plan before agreeing to any settlements.

I agree that any property/casualty, automobile, or workers' compensation carrier may release any personal health information about me related to this incident to Eliance Administrators. This authorization is valid during the reimbursement/subrogation process.

I certify that the above information is correct and understand that I am obligated to provide this information according to the provisions of the plan. My failure to provide complete and accurate information will result in a delay in the processing of my claims.

Signature: Date:

Print Name: Relationship to patient:

Caution: Any person who knowingly and with the intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.

Please return within 15 days.