Washington State Health Care Authority

TREATMENT QUESTIONNAIRE

Toll Free: 1-800-562-3022
PO Box 45561
Olympia, WA 98504-5561

PATIENT'S NAME	PATIENT'S TELEPHONE NUMBER ( )

Complete this form and return in the postage-paid envelope. We paid a medical bill for treatment of ____________ ________________________________ that was billed to us by ________________________________ for services on _____________. By law we have to see if any other insurance is available.

A. INCIDENT/ACCIDENT INFORMATION

CAUSE OF INJURY OR ILLNESS

- ☐ Motor Vehicle Accident
- ☐ Injured at work
- ☐ Assault
- ☐ Medical Condition/Illness (arthritis, diabetes, etc.) (Skip Sections A, B, & C; complete Section D on back.)
- ☐ Other (malpractice, fall, etc.) ________________________________

DATE OF INJURY FOR THIS INCIDENT/ACCIDENT

LIST ALL INJURIES FOR THIS INCIDENT/ACCIDENT

LOCATION WHERE ACCIDENT/INCIDENT/INJURY OCCURRED

STREET ADDRESS	CITY	STATE	COUNTY

B. ATTORNEY INFORMATION FOR THIS INCIDENT/ACCIDENT

Did you hire an attorney because of this incident/accident? ☐ Yes ☐ No If yes, fill out this section.

NAME OF ATTORNEY	ATTORNEY'S TELEPHONE NUMBER ( )

ATTORNEY'S ADDRESS	CITY	STATE	ZIP CODE

STATUS OF CASE ☐ Open/Pending ☐ Settled ☐ Case Lost	DATE CASE SETTLED	DATE CASE LOST

C. INSURANCE INFORMATION FOR THIS INCIDENT/ACCIDENT

Was anyone found at fault (did anyone get a ticket?) ☐ Yes ☐ No

If yes, who?) ________________________________

Was anyone else in your household in this accident? ☐ Yes ☐ No

If yes, who?) ________________________________

PLEASE COMPLETE BOTH SIDES

PERSON #1 IS: (At-fault party)	☐ Driver or operator ☐ Property owner	☐ Passenger ☐ Business owner	☐ Owner of car ☐ Other:

NAME			DRIVER'S LICENSE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
INSURANCE COMPANY'S NAME			
INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP CODE
INSURANCE REPRESENTATIVE			TELEPHONE NUMBER ( )
INSURED'S NAME	POLICY NUMBER		CLAIM NUMBER

☐ Liability coverage ☐ Personal injury protection coverage

PERSON #2 IS: (Injured party)	☐ Driver or operator ☐ Property owner	☐ Passenger ☐ Business owner	☐ Owner of car ☐ Other:

NAME			DRIVER'S LICENSE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
INSURANCE COMPANY'S NAME			
INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP CODE
INSURANCE REPRESENTATIVE			TELEPHONE NUMBER ( )
INSURED'S NAME	POLICY NUMBER		CLAIM NUMBER

☐ Liability coverage ☐ Personal injury protection coverage

If you have a police report or insurance card related to this treatment, please send a copy along with this form.

D. NARRATIVE

Tell us what happened. If you think someone is at fault, tell us why. If this is an ongoing illness/medical condition, tell us what the doctor told you about it. Use additional paper as needed.

PLEASE COMPLETE BOTH SIDES