Date: __________________

Third Party Liability/Workers' Compensation

Complete this form in full whether or not you, or your dependent, have had medical services related to an accident, illness or injury that are the responsibility of another person or third party or workers' compensation related. We must have your completed form within 30 days of the injury or illness or else any and all claims may be denied. One form is required for each injury/illness and for each person. It is recommended that you do not settle any personal injury claim without notifying the Plan Office.

RE: MY INJURY/ILLNESS OCCURRED ON ____

Patient: ____

Cause/Injury: ____

If medical services for you or your dependent are the responsibility of another person or third party, MPI is entitled to reimbursement from any recovery or settlement you have received or may receive from that third party or your own uninsured/underinsured motorist insurance, plus applicable interest.

If this matter is related to a work injury, you can find additional information in the Active Summary Plan Description, effective October 2013, on pages 53-54, or the Retiree Summary Plan Description, effective July 2007, on pages 38-39.

If you have any questions, please contact the MPI Plan office at (855) - ASK-4MPI (855-275-4674).

Sincerely,

BENEFITS RECOVERY DEPARTMENT

PLEASE COMPLETE, SIGN, AND RETURN THE QUESTIONNAIRE ON THE FOLLOWING PAGE OR YOUR CLAIMS MAY BE DENIED

rev 12/20/2015

Accident/Injury Questionnaire

CLAIMS WILL BE DENIED OR CONSIDERED OVERPAID

Return this form to: Benefits Recovery ● P.O. Box 1999 ● Studio City, CA 91614-0999
Toll Free: (855)275-4674 ● Fax: (818) 980-8661 ● Email: service@mpiphp.org

ATTENTION:
Whether or not the injury/illness was caused by another person or business, ***we still require the following information*** **or coverage may be interrupted for yourself or your dependents.**

Patient First:		Last:	Member First:	Last:	Date of Birth:
Patient ID #:	Contact Number: ( )		Other Family Members/Participants Involved in the Accident:		

1. DESCRIPTION OF INJURY/ILLNESS (Required)

Injury Caused On: _____/_____/________ Was Another Party At Fault? ☐ Yes ☐ No

How and where did the accident/injury happen? (An accident might include: motor vehicle accidents, falls, dog bites, assaults, medical malpractice injuries, work injuries, any injuries sustained at a business or public place, and/or any injury for which another party might be responsible)

____

____

____

What were your injuries: ______________________________

2. STATUS (Required)

☐ I have not and will not make a legal or insurance claim against the party responsible, my insurance, or my employer.

☐ Ongoing/Pending Legal or Insurance Claim. **Court Case Number:** _________________________

☐ Dropped/Lost Legal or Insurance Claim. ☐ Settled: ___/___/_____ (please include a signed copy of settlement)

(If status is Ongoing/Pending/Settled – complete sections 3, 4 and 5)

3. OTHER INSURANCE POLICIES AVAILABLE
(Check all that apply and/or provide coverage documents)

☐ Uninsured/Underinsured Motorist ☐ Homeowners ☐ Auto Insurance
☐ Med-Pay ☐ At-Fault Party's Insurance ☐ Workers' Compensation Carrier

Insurance Company/Carrier Name(s): **Phone:** ( )

Policy/Claim Number(s): **Policy Holder Name(s):**

4. WORK RELATED

Was this a work related injury? ☐ Yes (please attach DWC-1 Form) ☐ No

Your Employer: **Claim/Case Number:**

5. ATTORNEY CONTACT INFORMATION

Name: **Phone:** ( )

Address: **City:** **State:** **Zip:**

Agreement of Third Party Lien – If any amounts are received by me or by any person acting on my behalf as a result of a court judgment, arbitration award, settlement or any other arrangement from any third party or any third party insurer or from my uninsured or underinsured motorist coverage related to any illness or injury, I agree to pay such amounts or have such amounts paid to the Plan to the extent necessary to reimburse the Plan for any benefits paid with respect to such illness or injury with applicable interest on such amounts. My signature authorizes MPI to obtain any/all medical claim and accident information from any provider/carrier relating to this injury and to correspond with my attorney in order to receive protected health information and/or personally identifiable information for my case arising from the accident. I hereby grant a lien in favor of the Plan for the amount to which the Plan is entitled in accordance with the above from the proceeds, other arrangement, or from any amount received under uninsured or underinsured motorist coverage.

Signature: ___________________________ **Date:** ______________________________
Participant/Patient or Guardian's signature