Columbia Service Center
Post Office Box 100603
Columbia, SC 29260-9982
833-738-0978, ext. 43060

INSTIL HEALTH

**SUBSCRIBER:** _____
**ADDRESS:** _____
**ADDRESS:** _____

**PATIENT:** _____
**ID NUMBER:** _____

**PROVIDER**: _____
**CLAIM NUMBER**: _____

## ACCIDENT QUESTIONNAIRE
**TIME SENSITIVE MATERIAL** (Reply Immediately)

Dear Member:

Your health plan requires an Accident Questionnaire to make sure we provide proper benefits for members who may have received medical services related to an accident. To process your claims timely and accurately, we need information concerning your doctor's visit to determine if someone else is responsible for your injury or illness.

**FAILURE TO PROVIDE THIS INFORMATION WITHIN 180 DAYS MAY RESULT IN CLAIM DENIALS**

**There are multiple ways to complete this questionnaire:**

- **Phone:** Call 833-738-0978, extension 43060, between 8:30 a.m. and 4:30 p.m. EST, Monday through Friday.
- **Mail:** Answer the questions below and applicable questions on the back and return in the enclosed pre-paid envelope.
- **Fax:** Answer the questions below and the applicable questions on the back. Fax **both sides** of this form to 803-865-0654.

We thank you for your assistance and for allowing us to serve you.

Was the injury or illness:
- ☐ **Motor Vehicle Accident**
- ☐ **Work Related Accident**
- ☐ **Other Accident**
- ☐ **Assault**
- ☐ **No Accident**

Date of the injury or illness: _____

Where the accident or injury occurred (such as home, school, store, restaurant, etc.): _____

Briefly explain why you received treatment from this doctor and include body area(s) affected by this injury or illness:

_____
_____
_____

If you answered **NO ACCIDENT**, please sign below and return.

If you answered **MOTOR VEHICLE ACCIDENT**, **WORK RELATED ACCIDENT**, **OTHER ACCIDENT**, or **ASSAULT**, please answer the questions on the back of this page (use additional page if necessary), then sign and return.

Signature: _____
Date: _____

Daytime Phone Number: (____) _____
Evening Phone Number: (____) _____

**PATIENT:** _____
**PROVIDER**: _____

**ID NUMBER:** _____
**CLAIM NUMBER:** _____

If you answered **MOTOR VEHICLE ACCIDENT**, **WORK RELATED ACCIDENT**, **OTHER ACCIDENT**, or **ASSAULT** please answer the questions below (use additional page if necessary), then sign and return.

**We must receive your response within 180 days from the date of this letter. Failure to respond in this time period may result in permanent claim denials, and you may be responsible for paying the provider directly for the full charge amount.**

**If you checked "Motor Vehicle Accident," please answer the following:** (Please provide a copy of the police report.)
City and state of accident: _____
Was the motor vehicle: Auto ☐ Motorcycle ☐ ATV ☐ Other ☐ (Specify): _____
Was the patient: Driver ☐ Passenger ☐ Pedestrian ☐
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: _____ Phone: (____) _____ Adjuster's Name: _____
Was the patient wearing a seatbelt? Yes ☐ No ☐ a helmet? Yes ☐ No ☐
Auto insurance company of **patient**: _____ Policy/Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Name(s) of other family members injured in this accident: _____

**If you checked "Work Related," please answer the following:**
Name and address of patient's employer at the time of injury: _____
Name of workers' compensation carrier: _____ Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Have you filed a workers' compensation claim? Yes ☐ No ☐
Do you intend to file a workers' compensation claim? Yes ☐ No ☐
Has the employer or the workers' compensation carrier accepted or denied liability? Accepted ☐ Denied ☐
If denied, do you intend to file an appeal to the denial? Yes ☐ No ☐

**If you checked "Other Accident," please answer the following:**
Is someone else responsible for your injury or illness? Yes ☐ No ☐
If yes, name and address of the responsible person: _____
Did the accident occur on someone else's property? Yes ☐ No ☐
Does the person have insurance to cover your medical expenses? Yes ☐ No ☐
If yes, insurance company of the responsible person: _____ Policy/Claim #: _____
Address: _____ Phone: (____) _____ Adjuster's Name: _____
Do you intend to file a claim against the responsible person or insurance company? Yes ☐ No ☐

**If you checked "Assault," please answer the following:** (Please provide a copy of the police report.)
Name and address of the responsible person: _____
Name of law enforcement agency investigating the assault: _____ Case #: _____
Address: _____ Phone: (____) _____ Officer's Name: _____

**Attorney Information:**
Have you hired an attorney to assist you with this case? Yes ☐ No ☐
If yes, name, address and telephone number of your attorney: _____

Signature: _____ Daytime Phone Number: (____) _____
Date: _____ Evening Phone Number: (____) _____

**We must receive your response within 180 days from the date of this letter. Failure to respond in this time period may result in permanent claim denials, and you may be responsible for paying the provider directly for the full charge amount.**

Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination under Section 1557 of the Patient Protection and Affordable Care Act). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

We provide free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Section 1557 Coordinator at 1-888-713-3303 or by emailing Section1557Coordinator@myinstil.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by emailing Section1557Coordinator@myinstil.com or by calling 1-888-713-3303. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, email Section1557Coordinator@myinstil.com and assistance will be provided.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at InStil Health's website: https://www.instilhealth.com.

# Foreign Language Access

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

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Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

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如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

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Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

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이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오.
귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

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Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

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Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

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إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

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Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

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Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

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Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

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Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

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あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

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Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)