RISK MANAGEMENT DIVISION

Department of Administrative & Financial Services
85 State House Station, Augusta, ME 04333-0085

RMD File#

MEDICAL CLAIM QUESTIONNAIRE

Please complete all questions & sign at the bottom

Date of Accident _____ Time of Accident _____ AM PM

Name _____ Home Phone # _____

Address _____ Work Phone # _____

City, State, & Zip _____

Location of Accident _____

To whom did you report this accident? Please give name & telephone number _____

_____

Please give a description of the accident: _____

_____

_____

_____

_____

_____

_____

What is the nature of your injury? _____

_____

Were you treated at the scene of the accident? ☐ YES ☐ NO

If yes, by whom? _____

Did you seek further medical attention? ☐ YES ☐ NO

If yes, please complete the following if applicable:

Physician or Hospital name? _____

Address _____

PLEASE SIGN BOTH THIS FORM AND THE MEDICAL AUTHORIZATION FORM ON THE REVERSE SIDE. RETURN TO THE ADDRESS NOTED ABOVE. ATTACH ANY MEDICAL BILLS PERTAINING TO THIS ACCIDENT. THANK YOU.

I have read and completed this statement and it is correct to the best of my knowledge.

_____ _____

Signature Date

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Patient Name:_____ Date of Birth:_____

Address:_____ Apt#_____

City:_____ State:_____ Zip Code:_____ Ph#:(___)_____

I hereby authorize_____ to release copies of my medical records in their possession concerning my illness, treatment, or recommendations while I was a patient at their medical facility during the dates of:_____.

These records should be released to:

Name: _____ Phone # (_____) _____

Address: _____ Fax # (_____) _____

_____

I request the following information be released:
___ Inpatient hospital record ___ ER/First Care Visit ___History & Physical ___ Discharge Summary
___ X-Rays or EKG ___ Lab/Path report ___ Day Surgery/Endo. ___ Operative Report
___ Clinical Offices (specify)_____ ___ Other (specify)_____

I authorize the provider to use or disclose information related to (please initial):
_____ AIDS/HIV and other Communicable Disease
_____ Alcohol and/or Drug Abuse Treatment
_____ Mental Health Services provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.

The Purpose for releasing this information is: Legal Purposes

I understand I may revoke all or part of this authorization. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claims for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. This authorization will expire 90 days from the date I sign this form, or upon my request.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**