Detail of Incident Questionnaire

Our review process indicates you may have received healthcare services related to an incident or injury. In order for us to consider your claims, please complete, sign and return this form as soon as possible. Should the requested information be received within the timely filing limitation of the policy, your claim will be considered.

Please complete and sign this Questionnaire and mail it to:
Consolidated Health Plan, Inc.
2077 Roosevelt Ave., Springfield, MA 01104
Fax 413-733-4612 or Email: customerservice@consolidatedhealthplan.com

Questions? Please call CHP customer service at: 877-657-5030

Member Name: ____

Group name: ____

Insurance ID#: ____

Please provide the following information:

Date of incident: ________________ Body part (include left or right): ______________________

Where were you when the incident occurred (home, work, etc.): _________________________________

Explain how the incident happened: ____

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Is the incident work related: Yes ______ No______

Is the incident a result of a motor vehicle accident: Yes______ No______

*** If yes, please submit a copy of your auto PIP breakdown of payments and Exhaust Letter***
Please contact the auto insurance carrier to obtain these forms

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Is this incident sports related? Yes_______ No________

If yes: Intercollegiate __________ Intramural___________ Club__________ Recreational___________

Type of sport: ____

**** If intercollegiate and covered by a separate Sports plan, please provide a complete sports claim form signed off by the Athletic Director/Trainer*****

Member signature____ Date: _______________