Detail of Injury Questionnaire

Our review process indicates you may have received healthcare services related to an accident 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 Detail of Injury Questionnaire and mail it to:
Consolidated Health Plans, Inc., 2077 Roosevelt Ave, Springfield, MA 01104
Fax: (413) 733 – 4612 Email: customerservice@consolidatedhealthplan.com
Questions? Please call CHP Customer Service at 877-657-5030

Member Name: _____

Group Name: _____

Student ID: _____

Please provide the following information:

Date of Injury:_____Body Part (include left or right): _____

Where were you when the injury occurred (home, work etc.):_____

Explain how the injury occurred: _____
_____
_____

Is the injury work related: Yes _____ No _____

Is the injury 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. **

Is the injury 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: _____