**OFFICE OF RECOVERY SERVICES ACCIDENT - INJURY QUESTIONNAIRE**

**Complete both pages and return this questionnaire within ten (10) days to The Office of Recovery Services, Team 85, PO Box 45025, Salt Lake City, UT 84145-0025.**

**PLEASE PRINT**

|  |
| --- |
| **PERSONAL INFORMATION** |
| Name of injured person | (Patient Name) |
| ORS Case Number | (ORS Case Number) |
| Address of injured person |  |
| Phone number of injured person |  |  |  |
| **ACCIDENT/INJURY INFORMATION** |
| TYPE OF ACCIDENT | Auto | Work | Other (describe) |
| Date of accident/injury  |  |  |  |
| Where accident/injuryoccurred (include complete name, address and phone number) |  |
| Names of others involved | 1. |
|  | 2. |
| Explain how the accident or injury occurred |
| Name of Police Department |  | Police Report Number |  |

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| --- |
| **INSURANCE INFORMATION** **(for auto accident provide all insurance information from all parties;** **attach additional pages as needed)** |
| Type of Insurance | Auto | Health  | Other (describe) |
| Name of insurance |  |
| Address |  |
| Name of insured person |  |
| Phone number |  | Insurance Claim Number |  |
| **EMPLOYER INFORMATION** |
| Name of employer |  |
| Address |  |
| Phone |  | Employee ID Number |  |
| Worker’s Compensation Claim Filed | Yes No | Worker’s Compensation Claim Number |  |
| Worker’s Compensation Benefits (Describe) |  |
| **ATTORNEY INFORMATION** |
| Name |  |
| Address |  |
| Phone number |  |
| **OTHER INFORMATION OR COMMENTS** |
|  |
| Signature |  |
| Relationship to injured person |  |

**Attach additional pages if needed:**

[Tagline]