# Accident Victim Assistance — Insurance Denial Questionnaire

Facts about denied medical expenses after a pedestrian injury



**How to fill this out on your phone, tablet, or computer**
iPhone/iPad: open in Files or Adobe Fill & Sign — tap any field to type. Android: open in Adobe Acrobat Reader or Google Drive. Computer: open in Preview (Mac), Adobe Acrobat, or your web browser.
When done, save the filled PDF and email it to help@avahelp.org or text it to (888) 996-8814.

## 1. Personal Information

FULL LEGAL NAME *

DATE OF BIRTH (MM/DD/YYYY)

PHONE NUMBER *

EMAIL ADDRESS *

HOME ADDRESS

## 2. Accident Information

DATE OF ACCIDENT (MM/DD/YYYY)

TIME OF ACCIDENT

CITY AND COUNTY

EXACT LOCATION

DRIVER NAME, IF KNOWN

POLICE AGENCY / REPORT NUMBER

BRIEF DESCRIPTION OF HOW THE ACCIDENT HAPPENED

DRIVER STATUS (CHECK ALL THAT APPLY)

- ☐ Uninsured
- ☐ Unlicensed
- ☐ Unknown
- ☐ Other

## 3. Injury Information

DESCRIBE ALL INJURIES DIAGNOSED AFTER THE ACCIDENT

HOSPITALS, DATES OF ADMISSION/DISCHARGE, SURGERIES, AND CURRENT TREATMENT

DOCTOR WHO LINKED INJURIES TO THE ACCIDENT

## 4. Medical Providers and Bills

LIST ALL HOSPITALS, DOCTORS, SPECIALISTS, THERAPISTS, IMAGING CENTERS, REHAB FACILITIES, AND PHARMACIES

TOTAL AMOUNT BILLED TO DATE ($)

TOTAL AMOUNT DENIED ($)

ANY BILLS SENT TO COLLECTIONS?

HAVE ITEMIZED BILLS & RECORDS?

## 5. Health Insurance Information

INSURANCE COMPANY *

TYPE OF HEALTH PLAN

POLICY NUMBER

GROUP NUMBER

NAME OF POLICYHOLDER

COVERAGE ACTIVE ON ACCIDENT DATE? (YES/NO)

AVAILABLE DOCUMENTS

- [ ] Insurance card
- [ ] Policy
- [ ] Certificate of coverage
- [ ] Summary plan description

## 6. Claim Submission

WHO SUBMITTED THE CLAIM?

DATE FIRST CLAIM WAS SUBMITTED

HOW WAS THE CLAIM SUBMITTED?

ADDITIONAL RECORDS REQUESTED? (YES/NO)

WHAT SUPPORTING RECORDS WERE SUBMITTED, AND WHAT ADDITIONAL RECORDS WERE REQUESTED?

## 7. Denial Information

DATE OF DENIAL LETTER

DATE RECEIVED

ALL OR PART OF CLAIM DENIED?

APPEAL DEADLINE

EXACT REASON GIVEN FOR DENIAL

POLICY PROVISION, EXCLUSION, OR LIMITATION CITED IN THE DENIAL

REASONS CHECKED BY THE INSURER

- ☐ Not medically necessary
- ☐ Preexisting condition
- ☐ Not covered service
- ☐ Out of network
- ☐ Late filing
- ☐ Other

## 8. Communications and Appeal

CALLS, LETTERS, EMAILS, PORTAL MESSAGES, AND WHAT THE INSURER SAID

ANY APPEAL FILED AND THE INSURER'S RESPONSE

PREEXISTING CONDITION, PRIOR TREATMENT, OR DOCTOR EXPLANATION LINKING INJURIES TO THE ACCIDENT

## 9. Financial Impact

COLLECTIONS, LOST INCOME, CREDIT IMPACT, OR TREATMENT DELAYS CAUSED BY THE DENIAL

## 10. Free Legal Consultation Consent

I consent to receive a free legal consultation so I can understand my rights and options after this accident and insurance denial. I understand this consultation is free and that I am not obligated to take any further action. All information I have shared on this form is true and complete to the best of my knowledge.

CONSENT TO FREE LEGAL CONSULTATION? (YES/NO) *

INFORMATION TRUE AND COMPLETE? (YES/NO) *

SIGNATURE (TYPE YOUR FULL NAME) *

DATE *