UW-Madison SHIP Accident/Injury Questionnaire

A claim has been received by Consolidated Health Plans, the Claims Administrator for the UW-Madison Student Health Insurance Plans (SHIP). Before this claim can be considered for processing, you must complete all applicable sections and return this completed questionnaire to: Consolidated Health Plans, 2077 Roosevelt Ave., Springfield, MA 01104.
If you have any questions regarding the completion of this questionnaire, please contact Consolidated Health Plans 1-877-657-5031.

Section A: Member and Claimant Information

Name of Primary SHIP Member: _____

Street Address, City, State, Zip: _____

Daytime Phone: _____ Alternate Phone: _____

This claim is being made for (check one box): ☐ Self ☐ Spouse/Partner ☐ Dependent Child

Name of Claimant (if not self): _____ Claimant Date of Birth: _____

(From SHIP Card) Group #: _____ Claimant Member #: _____

Is this claim related to an illness?

☐ Yes (skip Section D: Signature)

☐ No (complete Section B: Description of the Accident of Injury)

Section B: Description of the Accident or Injury

Was the Accident or Injury:

Due to an intercollegiate sports event or practice?	☐ Yes	☐ No
Due to a work-related accident?	☐ Yes	☐ No
On school grounds?	☐ Yes	☐ No
On someone's premises?	☐ Yes	☐ No
Due to an act of violence?	☐ Yes	☐ No
Due to food poisoning?	☐ Yes	☐ No
Due to drug poisoning?	☐ Yes	☐ No
Due to a motor vehicle accident?	☐ Yes	☐ No

If due to a motor vehicle accident, you must ALSO complete Section C.

Date of Accident or Injury: _____ Location: _____

Brief Description: _____

_____

_____

_____

Treating Physicians (*if more than one, please use additional line below*):

Name: _____ Phone: _____

Street Address, City, State, Zip: _____

Name: _____ Phone: _____

Street Address, City, State, Zip: _____

(Please complete other side)

Claimant's Attorney (i*f applicable*):
Name: _____ Phone: _____
Street Address, City, State, Zip: _____

Please Provide any additional information regarding this incident that you believe would be helpful:
_____
_____
_____

Section C: Auto Accident Information (*if applicable*)
The claimant was (check one box): ☐ Driving ☐ A Passenger ☐ A Pedestrian

For prompt service, if this injury is due to an auto accident, please submit Personal Injury Protection statements from your insurance company with this questionnaire.

Complete the following information regarding auto insurance coverage:
Auto Insurance Company: _____ Policy Number: _____
Name of Insurance Agent: _____ Phone: _____
Street Address, City, State, Zip: _____

Was another vehicle involved? ☐ Yes ☐ No
If yes, complete the following regarding the other driver and vehicle:
Other Driver's Name: _____ Phone: _____
Address, City, State, Zip: _____
Auto Insurance Company: _____ Policy Number: _____
Name of Insurance Agent: _____ Phone: _____

Police Department of Emergency Service that Rendered Assistance:
Name: _____ Phone: _____
Address, City, State, Zip: _____

Section D: Signature
Please read and sign:
I have completed this questionnaire and carefully read its contents. I attest to the accuracy and completeness of the information I have provided.

_____ _____
Signature of Claimant or Parent/Guardian Date (mm/dd/yyyy)