More Than Just Insurance.
Plymouth Rock assurance

Medical Payments Questionnaire

To complete this form by hand:

1. Print all pages of the form.
2. Complete the form by filling in each space with black or blue ink. Do not use pencil.
3. When finished, mail the form to Plymouth Rock's Claims Department at the address provided at the bottom of the form.

Or

To complete this form electronically:

1. Save this writable PDF to your computer, then open it using Adobe's Acrobat Reader.
2. Complete the form by typing in each field and/or checking the appropriate buttons. *Tip: you can tab from field to field.*
3. When finished, save and print the form. Then mail the form to Plymouth Rock's Claims Department at the address provided at the end of the form.

Complete this form to the best of your knowledge and belief. DO NOT GUESS at any answers. If you don't know the answer to a question, leave that field blank. Please call your Claim Representative if you need help.

CLAIM NUMBER	*(12-digit number)*

To enable us to more efficiently investigate potential coverage under Medical Payments optional coverage, please complete this form and return it promptly to the address provided on the last page.

YOUR PERSONAL INFORMATION

First Name:		**Last** Name:	
Date of Birth: / /	Social Security Number: - -		
Street Address:	City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	

ACCIDENT & INJURY INFORMATION

Date of Accident: / /	Time of Accident: : ◯ am ◯ pm	
Street Address Where Accident Occurred:		
City:	State:	

Brief Description of the Accident

At the time of the accident,

were you the **driver** of our policyholder's car?	◯ Yes	◯ No
were you a **passenger** in our policyholder's car?	◯ Yes	◯ No
were you a **pedestrian**?	◯ Yes	◯ No
were you a **member** of our policyholder's household?	◯ Yes	◯ No

Form continues

Medical Payments Questionnaire (continued)

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As a result of this accident, were you injured? ◯ Yes ◯ No
IF YES, complete the remaining questions below and the form on the next page.
IF NO, sign directly below and return this questionnaire.

✘ _____ / / _____

Signature ***(Sign here only if you were NOT injured in the accident.)*** Date

Describe Your Injury

Were you treated by a doctor? ◯ Yes ◯ No			
IF YES, Doctor's **First** Name:	Doctor's **Last** Name:		
Street Address:	City:	State:	Zip Code:
IF TREATED IN A HOSPITAL, were you an: ◯ In-Patient ◯ Out-Patient?			
Amount of Medical Bills to Date: $	Will you have more medical expenses? ◯ Yes ◯ No		
Your Health Insurance Company:		Policy Number:	
As a result of your injury, have you had any other expenses? ◯ Yes ◯ No			
IF YES, Please Explain:			

✘ _____ / / _____

Signature Date

Additional form on next page

HIPAA Compliant Authorization for the Release of Patient Information Pursuant to 45 CFR 164.508

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CLAIM NUMBER	*(12-digit number)*	

TO			
Name of Healthcare Provider / Physician / Facility / Medicare Contractor:			
Street Address:	City:	State:	Zip Code:
Patient's **First** Name:	Patient's **Last** Name:		
Date of Birth: / /	Social Security Number: - -		

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/ monographs. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period *(date of loss)* ____/____/____ to *(present date)* ____/____/____ . I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the following purposes: Automobile claim disposition.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

To be completed by an authorized representative of Plymouth Rock Assurance			
Adjuster's Name:	Name of Representative:		
Representative Capacity: *(e.g., Attorney, Records Requestor, Agent, etc.)*			
Street Address:	City:	State:	Zip Code:

I understand the following:
See 45 CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

✘ _____ / /

Signature of Patient or Legally Authorized Representative (See 45 CFR § 164.508(c)(1)(vi)) — **Date**

_____

Name of Legally Authorized Representative (See 45 CFR § 164.508(c)(1)(vi)) — **Relationship**

✘ _____ / /

Witness Signature — **Date**

Return This Form To

Claims Department
Plymouth Rock Assurance Corporation, PO Box 9112, Boston, MA 02112-9112

Thank you.

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