



STATEMENT OF INCIDENT

QUESTIONNAIRE

INSTRUCTIONS FOR COMPLETION OF QUESTIONNAIRE

You must provide all information that pertains to the circumstances of your injury. For sections that do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The attached law, Title 32 Code of Federal Regulations, Section 220.9, which requires completion of this form applies equally to active, retired, or separated United States Army personnel and/or their family members. If you are represented by an attorney, refer this questionnaire to your attorney for assistance.

* * * **RETURN COMPLETED QUESTIONNAIRE TO:** * * *

Office of the Staff Judge Advocate, Claims Division, 7090 Alabama Ave, Building 1454, Fort Polk, LA 71459

INJURED PARTY

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	HOME TELEPHONE	WORK TELEPHONE

MILITARY SPONSOR

BRANCH OF SERVICE					SPONSOR'S STATUS				
(Check One): USA <input type="checkbox"/> USAF <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> OTHER <input type="checkbox"/>					(Check One): Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> ETS'd <input type="checkbox"/> Deceased <input type="checkbox"/>				
NAME (Last, First, MI)					GRADE/RANK		SPONSOR'S SSN		
MILITARY UNIT MAILING ADDRESS (if sponsor is on active duty)							UNIT TELEPHONE		

DETAILS OF THE INCIDENT

DATE	TIME AM <input type="checkbox"/> PM <input type="checkbox"/>	COUNTY
STREET	CITY	STATE
POLICE AGENCY INVESTIGATION ?: IF YES, NAME OF AGENCY	YES <input type="checkbox"/> NO <input type="checkbox"/> TRAFFIC ACCIDENT REPORT #	MILITARY <input type="checkbox"/> CIVILIAN <input type="checkbox"/> ACCIDENT REPORT ATTACHED? YES <input type="checkbox"/> NO <input type="checkbox"/>
WAS A CITATION ISSUED? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, TO WHOM	CITED FOR

IN YOUR OWN WORDS, *please describe below*: (1) The circumstances of exactly *how* the incident occurred, (2) How *you* came to be injured, and (3) *Who* (if anyone) was at fault. (Please PRINT)

MOTOR VEHICLE ACCIDENTS

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the Office of the Staff Judge Advocate.

I WAS A:				DRIVER	PASSENGER	PEDESTRIAN	BICYCLIST	OTHER
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
YOUR VEHICLE	YEAR	MAKE	MODEL					
NAME OF DRIVER		ADDRESS						
NAME OF OWNER (if different than driver)		Address & Phone #						
Insurance Co & Policy #		Address & Phone #						
Claim #		Adjusters Name						
IS A COPY OF THE AUTO POLICY ATTACHED ? :								
TYPES OF POLICY COVERAGE: Check (3) all types that apply and indicate coverage amounts:		<input type="checkbox"/> Personal Injury Protection (PIP) Coverage Amount \$		<input type="checkbox"/> Medical Payments (MedPay) Coverage Amount \$		<input type="checkbox"/> Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount \$		<input type="checkbox"/> Yes <input type="checkbox"/> No
THE OTHER VEHICLE	YEAR	MAKE	MODEL					
NAME OF OTHER DRIVER		ADDRESS						
NAME OF OTHER VEHICLE'S OWNER		Address & Phone #						
OTHER DRIVER'S INSURANCE COMPANY		Address & Phone #						
Policy & Claim #		Adjusters Name						

WORKER'S COMPENSATION CLAIM

NAME OF BUSINESS/ORGANIZATION	ADDRESS
EMPLOYER'S INSURANCE COMPANY	ADDRESS
NAME OF CLAIMS ADJUSTER	CLAIMS ADJUSTER'S TELEPHONE NUMBER
WORKER'S COMPENSATION CLAIM NUMBER:	OTHER INFORMATION:

OTHER TYPES OF INCIDENTS

INJURY OCCURRED AT:	MY HOME	OTHER RESIDENCE	SCHOOL	PUBLIC PROPERTY	PRIVATE PROPERTY
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAME OF PROPERTY OWNER			ADDRESS		
NAME OF INSURANCE COMPANY			ADDRESS		
NAME OF CLAIM ADJUSTER			CLAIM ADJUSTER'S TELEPHONE NUMBER		
INSURANCE POLICY NUMBER:			INSURANCE CLAIM NUMBER:		

MEDICAL CONDITION

DESCRIBE BELOW WHAT INJURY or INJURIES WERE EVALUATED OR TREATED AS A RESULT OF THIS INCIDENT:

(Please be specific when describing the nature and severity of your illness/injuries, being careful to include "Left" or "Right", when specifying bodily location. Also indicate if any surgeries or tests have been performed or will be performed).

LIST BELOW THE NAMES OF MILITARY FACILITIES PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

MILITARY MEDICAL FACILITY(IES):

Other Military Facility
(Please specify) :

LIST BELOW THE NAMES OF CIVILIAN FACILITIES PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

NON-MILITARY MEDICAL FACILITY(IES):

(or Doctor's Name)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID? NO <input type="checkbox"/> YES <input type="checkbox"/> (IF "Yes," please specify by whom) :	ME <input type="checkbox"/>	ARMY <input type="checkbox"/>	CHAMPUS <input type="checkbox"/> (TRICARE)	INSURANCE <input type="checkbox"/>	ATTORNEY <input type="checkbox"/>	OTHER <input type="checkbox"/>
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MISCELLANEOUS INFORMATION (Required)	PLEASE SPECIFY
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Do you <i>handcarry</i> your medical record? YES <input type="checkbox"/> NO <input type="checkbox"/>	Where kept:
Are you still receiving treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, Where:
Have you signed any release form? YES <input type="checkbox"/> NO <input type="checkbox"/>	From Whom:
Has property damage been paid? YES <input type="checkbox"/> NO <input type="checkbox"/>	By Whom:
Has personal injury been paid? YES <input type="checkbox"/> NO <input type="checkbox"/>	By Whom:
Did you miss any duty days? (*) YES <input type="checkbox"/> NO <input type="checkbox"/>	List Dates:

(*) NOTE: Active Duty soldiers who missed complete duty days -must- submit a copy of their Leave and Earning Statement (LES) -and- complete a "CERTIFICATION STATEMENT of Military Services Due to Third Party Incident" (attached).

ATTORNEY REPRESENTATION

NAME OF LAW FIRM	ADDRESS
ATTORNEY'S NAME	ATTORNEY'S TELEPHONE NUMBER/FAX NUMBER
CHECK THIS BOX: IF YOU HAVE -NOT- RETAINED THE SERVICES OF AN ATTORNEY RELATIVE TO THIS INCIDENT: <input type="checkbox"/>	

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I hereby acknowledge receipt of the "Advice to Injured Party" form and understand that use of this information is authorized by law in pursuing claims in favor of the U.S. Government.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)
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I HAVE ATTACHED THE BELOW-LISTED DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:

- | | |
|--|--|
| <input type="checkbox"/> Traffic Accident Report | <input type="checkbox"/> Leave & Earning Statement (LES) |
| <input type="checkbox"/> Auto Accident Diagram | <input type="checkbox"/> Military Medical Record Copies |
| <input type="checkbox"/> Insurance Policy Copy | <input type="checkbox"/> Other Document(s) |

Release for Use of Medical Records under HIPAA

Use of Medical Records

As evidenced by my signature below, I, _____, (name of patient, natural or legal guardian or estate representative) have read the attached explanation of my privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). I hereby grant authority to the United States Army claims representatives to obtain, copy and release for review, protected information (PHI), including medical and dental records, whether civilian or military, for the purpose of evaluating the United States' claim for medical care expenses.

I understand that PHI in the possession of the Army claims representative may be copied and disclosed to other agencies, civilian entities, experts, or consultants for purpose of investigating and evaluating the claim.

A photostatic copy of this document shall be valid as the original. This authorization will remain in effect until such time that a final resolution of the administrative claim for compensation has been determined.

Printed Name of Patient

Patient's Social Security Number

Signature of Patient
(If Signed by a Legal Representative, List Relationship to Patient)

Patient's Date of Birth

Date Signed

MEMORANDUM FOR: Any Physician, Hospital or Clinic

SUBJECT: Release of Medical Information

MEDICAL INFORMATION

I hereby authorize you to release to the Medical Claims Judge Advocate, Office of the Staff Judge Advocate, Fort Polk, Louisiana, any medical information, including inpatient records, X-rays or other pertinent information, regarding the injuries I sustained in an accident on _____.

FURTHER:

I hereby authorize the Medical Claims Judge Advocate, Office of the Staff Judge Advocate, Fort Polk, Louisiana, in pursuit of its claims under the Federal Medical Care Recovery Act, to disclose to the appropriated parties, any information, including copies of medical records, concerning the treatment rendered to me at any government medical facility or at government expense. Only that information which pertains to the injuries I sustained on _____.

DATE

SIGNATURE

AGREEMENT OF CLAIM

Pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. 2651-2653, I hereby assign to the United States of America and its representative's any and all claims and benefits for the cost of medical care provided at the expense of the United States for injuries sustained on _____ at _____.

The United States is authorized to recover said costs independently of any claim for pain and suffering, consequential, special or punitive damages which I may have as a result of this incident, from any and all sources to which I may submit such claims for medical costs. The United States is authorized to act in my stead in completing any and all actions necessary to claim said cost. No release signed by myself, or my representatives shall operate to the prejudice of the United States.

Payment of the costs of such care described above shall be mad directly to the United States per direction of the Department or Agency concerned. Payment made directly to me for medical care paid or furnished by the United States, without the express consent of the United States.

Because this assignment is mandated by Federal Regulations (2 C.F.R. 43.2), it may not be revoked except with the express consent of the United States.

DATE

SIGNATURE

ADVICE TO INJURED PARTIES

1. Under federal law, the United States may be entitled to recover the reasonable value of medical care provided or to be provided to you. This claim would be asserted against the person responsible for your injury.
2. You may seek guidance from a legal assistance attorney regarding any cause of action you may have for personal injury.
3. You are required to cooperate with the Claims Judge Advocate as he or she processes the United States government's claim.
4. You are required to furnish a complete statement regarding the circumstances surrounding the incident that resulted in your injury. Completing the enclosed Medical Care Recovery Program Injury Information Paper (Statement of Incident) will satisfy this requirement.
5. You are required to furnish the Claims Judge Advocate information concerning any legal action brought or to be brought by or against the person responsible for your injury. You are also required to provide the Claims Judge Advocate the name and address of your attorney.
6. Your failure to cooperate with the Claims Judge Advocate may result in the hospital withholding your medical records from you or your attorney and disqualifying you for future health care services.
7. You should not execute a release or settle any claims you may have as a result of the injury without first notifying the Claims Judge Advocate.

I, _____, have carefully read and understand the above information. I understand I must promptly return one signed copy of this form along with a signed Medical Release to:

Office of the Staff Judge Advocate
Claims Division
7090 Alabama Avenue, Building 1454
Fort Polk, Louisiana 71459

Date

Signature

Date

Signature

Date

Signature