



Your Health Is Our Business

737 Bishop Street, Suite 1200  
Honolulu, Hawaii 96813  
Phone: (808) 941-4622  
Toll-Free: (888) 941-4622

### QUESTIONNAIRE TO DETERMINE THIRD-PARTY LIABILITY

In order to determine benefits for your claim(s), HMAA requires the following additional information for services that may be the result of an accident or injury. ALL QUESTIONS REQUIRE A RESPONSE. Please note the failure to respond may result in the denial of your claims. Upon completion, please sign and date this form and return it to the address above, ATTN: Claims Department, or via fax at (808) 535-8342. If you have any questions, please feel free to call Customer Service at 941-4622 or toll-free at 1-888-941-4622.

INSURED'S NAME		PATIENT'S NAME	
MEMBER ID#		DATE OF SERVICE	
DIAGNOSIS			

1. Please provide exact details as to how, when and where this accident/injury occurred: (If additional space is required, please attach a sheet): \_\_\_\_\_

2. Was the accident or injury related to work?  
 Yes - Name and address of employer: \_\_\_\_\_  
 No - Skip to #4.

3. Have you filed for Workers' Compensation?  Yes  No - Please explain: \_\_\_\_\_

4. Did the accident or injury involve a motor vehicle?  Yes  No  
If YES, name, address & policy number of insurance carrier: \_\_\_\_\_

5. Is another party potentially responsible for your accident or injury?  Yes  No  
If YES, did you file a claim or lawsuit?  Yes  No, but I plan to file a claim or lawsuit.  
 No, and I do not plan to file a claim or lawsuit.

6. Was a police report made?  Yes  No

Note: Please submit a copy of the accident and police reports, if these were made. If this incident is related to an automobile accident, please also obtain and submit a copy of your insurance recap sheet, plus any letter received from your insurance carrier that states you have exhausted benefits available under your policy. If your accident or injury is work-related, submit a copy of your worker's compensation claim and any related reports.

7. Have you retained legal counsel?  Yes - Name and address of legal counsel: \_\_\_\_\_  
 No, but I plan to retain legal counsel.  No, and I do not plan to retain legal counsel.

Completed by: \_\_\_\_\_  
Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Please fax this form to (808) 535-8342 or mail to the address shown above.

This is a reminder that HMAA has a lien and right to reimbursement for any payment HMAA makes in connection with injuries or illness for which a third party may be responsible for payment and that HMAA has a right to repayment from any recovery, settlement, or judgment you receive.

Additionally, the Hawaii Revised Statutes, Chapter 431:13-103 (a) (10) stipulates that "Any individual who knows or reasonably should know that they have a third-party claim for recovery of damages and who fails to provide timely notice of potential claim to the health plan shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage."