GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Russel Carlson, Commissioner**

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | www.dch.georgia.gov

APRIL 13, 2024

5

MEDICAL SERVICE QUESTIONNAIRE

Please Direct Questions to Health Management Systems, Inc. (HMS) Recovery Unit: (678) 564-1163
Regarding:
Medicaid ID:
Medical Service Date:
Medical Provider(s): H
Treatment: DISPL INTERTROCH FX R FEMUR, SUBS FOR CLOS FX W ROUTN HEAL

YOU MUST RETURN THIS FORM IN THE ENCLOSED POSTAGE PAID, SELF-ADDRESSED ENVELOPE WITHIN TEN (10) DAYS TO:

GAINWELL TECHNOLOGIES
100 CRESCENT CENTRE PKWY
STE 1000
TUCKER, GA 30084

The person named above received medical care on the medical service date listed above. This medical care (for example, treatment at a hospital, clinic, or doctor's office) was billed to Medicaid and may have been related to an injury. Please fill out the following questions and return it in the enclosed envelope.

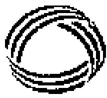
1. Reason for Medical Care:

_____Auto Accident _____Bicycle Accident _____Motorcycle Accident
_____Slip/Fall _____Assault _____Medical Malpractice
_____Pedestrian _____Illness _____Worker's Compensation
_____Other (explain)____

2. Was there an injury? Yes_____ No_____
If No, sign and return the form. If Yes, continue to answer the following questions.
Date of injury: _______________
Place of injury (give address): _______________________________
(Street Address)
____
(City, State and Zip Code)

Describe what happened and the kind of injury received:

____
____
____



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Russel Carlson, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | www.dch.georgia.gov

3. If the injury is work related, provide the following information:
Employer's Name: ______________________________
Employer's Address: ______________________________
____
Employer's Phone #: ______________________________

Was the injury reported to the employer or workers compensation? Yes_____ No_____

4. Did the injury occur as the result of a motor vehicle accident? Yes_____ No_____
If Yes, provide the following information:
Auto Insurance Name: ______________________________
Auto Insurance Address: ______________________________
____
Auto Insurance Phone #: ______________________________
You were a:

_____Passenger _____Pedestrian _____Motorcycle Rider
_____Driver _____Bicycle Rider

5. If the injury happened on someone's property (for example: at school, friend's or relative's home), provide the following information:
Property Owner's Name: ______________________________
Property Owner's Address: ______________________________
____
Property Owner's Phone #: ______________________________
Do you have homeowners or renters insurance? Yes_____ No_____

6. Do you plan to bring legal action against anyone for this injury? Yes_____ No_____ Unknown_____
If Yes, provide the following information:
Attorney's Name: ______________________________
Attorney's Address: ______________________________
____
Attorney's Phone #: ______________________________
Provide the trial date (if known):_______________

7. I hereby declare that the information I have stated on this form is accurate and complete:

______________________________ ______________________ ____________
Signature* Telephone Number Date Date

*If you are completing this form on behalf of the member, indicate your relationship and the reason they cannot complete the form:

______________________________ ______________________________
Relationship Reason you are signing for Member