University of Missouri Health Care
Liability and Accident Questionnaire
PO BOX 843966
Kansas City, MO 64184-3966

Patient Name:_____ **Visit #:** _____
MRN:_____ **Date of Injury:** _____

1. **Was this related to an accident?** **Yes** ☐ **No** ☐
2. **What type of accident did you have?** **Auto** ☐ **Fall** ☐ **Other:**_____
3. **Describe the details of the accident:**_____
   _____
   _____
   _____
4. **When did the accident occur? Date:**_____ **Time:**_____
5. **Where is the exact location/address of the accident?**
   Street: _____ **Block:**_____
   City,ST: _____ **Zip:**_____ **County:**_____
6. **Did this accident occur in your home or property? Yes** ☐ **No** ☐
7. **Could someone else's Homeowners Insurance be held responsible for this? Yes** ☐ **No** ☐
8. **Is there an Accident Report? Yes** ☐ **No** ☐
   a. **If Yes who took the report (example: County Sherrif, City Police, Highway Patrol, etc.):**
   _____
9. **Who could be responsible for the accident?**
   Name:_____ **Phone:**_____
   Address: _____ **Relationship:** _____
   _____
10. **Does the responsible person have insurance that may cover your services?**
    Company: _____ **Phone:** _____
11. **Is there a claims adjustor working this case?**
    Name: _____ **Phone:** _____
    Claim #: _____ **Fax:** _____
12. **Are you represented by an attorney?**
    Name: _____ **Phone:** _____
    Address: _____ **Fax:** _____
13. **Who is your Auto insurance?**
    Name: _____ **Phone:** _____
    Claim #: _____ **Fax:** _____
14. **Do you have Medical Coverage Through your Auto Insurance Policy? Yes** ☐ **No** ☐

If you have questions regarding this form, please contact
Customer Service at (573) 884-3300 or (800) 877-2372
Please return this form in the envelope provided, or fax to (573) 884-0937,
or email to UMHCSelfPayTeam@missouri.edu