

# AmeriHealth Administrators Subrogation Form

## Injury or Illness Inquiry

Member ID / Agreement # \_\_\_\_\_ Sub # \_\_\_\_\_

Patient Name \_\_\_\_\_

Condition: \_\_\_\_\_  
\_\_\_\_\_

• Was this condition related to any of the following? (Choose one.)

- |   |  |
|---|--|
| <input type="checkbox"/> A work accident or illness | <input type="checkbox"/> An injury caused by another party                                 |
| <input type="checkbox"/> An automobile accident     | <input type="checkbox"/> An accident in someone else's home                                |
| <input type="checkbox"/> A motorcycle accident      | <input type="checkbox"/> An accident in a business establishment other than the employer's |
| <input type="checkbox"/> Other                      | <input type="checkbox"/> Not an accident or injury   |
| <input type="checkbox"/> A school related accident  |  |

• Date of accident or onset of condition: \_\_\_\_\_

• Briefly describe the accident or the onset of the condition, including the location.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. If the condition is work related, and the patient is your dependent, provide the name and address of the dependent's employer.

Employer's Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_  
Contact: \_\_\_\_\_

2. If the condition was auto related, provide the following:  
Patient's Auto Insurance Carrier:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_  
Contact: \_\_\_\_\_  
Policy # \_\_\_\_\_

3. If the condition was motorcycle related, provide the following:  
Patient's Motorcycle Insurance Carrier:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_  
Contact: \_\_\_\_\_  
Policy # \_\_\_\_\_

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