

Accident/Injury Report Form

RE: PATIENT NAME:
MEMBER #:
GROUP:
DATE OF ACCIDENT:

We are in receipt of a claim for the above named patient. The diagnosis on the claim indicated that the services provided may be due to an accident or injury that may be covered under another party's insurance. Please complete the following questions for continued claim processing:

1. Was this due to an accident? _____ Yes _____ No If Yes, continue. If No, sign and date here and return the form.

Signature: _____ Date _____

2. Where did the accident take place? _____ Work _____ Home _____ Auto _____ Other

3. What was the date of the accident? _____

4. Please provide a brief description of how the accident occurred. (If additional space is needed, please continue on the back of this form).

5. Has civil or criminal action been initiated by or against claimant as a result of the incident causing the injury or illness? _____ If so, please explain:

6. I have inquired and other coverage (e.g. Workers Compensation, School, Premises, Medical Malpractice) _____ is or _____ is not available. If available, provide name and address of insured person, the insurance type, and the name, address, policy number and phone number of their insurance company:

7. Did a law enforcement officer investigate? _____ Yes _____ No

If Yes, please attach a copy of the official report of the accident/incident. For motor vehicle accidents, please note that an Exchange Slip or Notice of Requirement is NOT sufficient.

If the injury/illness/disease was not the result of an accident involving a motor vehicle, bicycle, all terrain vehicle, etc., you may skip this section.

1. Name, address, telephone number and policy number of claimant's automobile insurance:

2. Enclose a copy of the declaration page for claimant's automobile insurance policy.

3. If claimant was a passenger in a vehicle registered to another person, provide the name and address of that person and the name, address, telephone number, and policy number of that person's automobile insurance company. Provide copy of the declaration page for that policy.

4. Name address, telephone number and policy number of the insurance covering the other vehicle(s) involved in the collision.

5. Has an attorney been retained by the claimant in connection with this incident? If so, provide attorney's name, address and phone number:

SUBROGATION NOTIFICATION

Since your plan contains a Subrogation clause, it is necessary that we advise you that a Participant in the plan (or your dependent), You must reimburse the Plan for benefit paid by the Plan from any monies you (or your dependent) receive, in whole or in part, from a judgment or settlement, made by a third party from any recovery. You as the participant or the dependent must also take action to assist the Plan in recovering this reimbursement. You or your dependent must sign and deliver all necessary documents that the Plan may need to enforce its rights to obtain reimbursements.

Signature _____ Date _____

The information provided on this Statement of Injury/Illness is complete and true to the best of my knowledge.

PAYMENT OF THIS CLAIM IS PENDING YOUR RESPONSE

If you have any questions, please contact our office at 434-799-3838

SINCERELY,
CLAIMS DEPARTMENT
GATEWAY HEALTH ALLIANCE