

Accident Form



PO Box 709718
Sandy, UT 84070-9718
Customer Service 800-894-9454

Member Name: (print)	Claim #:	Member ID#:
Was the treatment in question a result of one of the following: Date of Injury: _____ <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Injured at patient's home <input type="checkbox"/> Injured on someone else's property <input type="checkbox"/> Injured at work <input type="checkbox"/> Other		
Please briefly describe what happened or lead to the accident or injury: 		
Motor Vehicle Accident (Auto, Motorcycle, Boat or ATV)	Patient was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motorcyclist State accident or injury occurred: _____ List all family members involved: _____ Auto Insurance Carrier: _____ Claim/Policy: _____ Adjusters Name: _____ Phone: _____ Other Party's Insurance Carrier: _____ Claim/Policy: _____ Adjusters Name: _____ Phone: _____	
Injury was Work Related	Employers Name: _____ Phone: _____ Work Comp Insurance Carrier: _____ Phone: _____ Adjusters Name: _____ Phone: _____	
Injury Occurred on Someone Else's Property	Name of Other Party: _____ Other Party's Address: _____ City: _____ State: _____ Zip Code: _____ Their Insurance Carrier: _____ Claim #: _____ Adjusters Name: _____ Phone: _____	
Attorney Information	Are you pursuing a personal injury claim: <input type="checkbox"/> Yes <input type="checkbox"/> No Attorney Name: _____ Phone: _____ Law Firm Name: _____ Has the Claim been Settled: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Settled: _____ With whom did you settle: _____	
The above information is true and correct to the best of my knowledge:		
Member Signature: _____ Date: _____		

Please Mail Form to: PO BOX 709718 Sandy, UT 84070

