

Accident Description Form

Member's Name		Soc. Sec. #	
Patient's Name		Date of Accident	
Description of Injury			
Location of Accident			

Was Accident Job-Related?	If Yes, Employer's Name:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Telephone:	()
	Accident Reported to Employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Complete if Accident Involved a Motor Vehicle	Patient Was:	<input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian	Licensed in State of:		
	Auto Insurance Company				
	Policy No.				
	Other Drivers Information	Name			
		Ins. Co.			
		Driver's Phone #			
Adjuster Name					
	Claim #				

Complete if Accident Did NOT Involve a Motor Vehicle	Did Injury Occur on Someone Else's Property?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Property Owner:	
	Owner's Insurance Company		Adjustor's Name	
	Policy No.		Telephone	

Have you received any settlement or insurance money because of your injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:	Amount Paid:	
			Date Paid:	
			Who Paid:	

Do you intend to make any claims other than Health claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you hired an attorney because of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attorney's Name			
Address		Telephone	

NOTE: Please provide a copy of a police and/or accident report if made.

If none of the above applies, please explain:

The foregoing is true and correct to the best of my knowledge.

Member's Signature		Date	
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