INCIDENT REPORT

PRINT PATIENT NAME:_____

INS ID #_____

According to our information, the treatment received on the date(s) specified above may have been the result of an injury or accident. We need additional information to complete the processing of this claim. Without this information, claims may be denied or paid incorrectly. When additional information is required and claims are held for return of that information, we may extend the overall time taken to process the claim to include an additional 15 days.

BRIEFLY DESCRIBE THE CIRCUMSTANCES THAT CAUSED YOU TO SEEK TREATMENT

_____

_____

If these circumstances relate to a specific incident or event, please complete the following questions.

1. Was treatment the result of a motor vehicle accident yes ( ) no ( )
2. If YES what type of vehicle was it_____
3. Name and address of insurance company

   _____

   _____

   Adjusters name and telephone number

   _____
4. Did this medical condition occur on the job yes ( ) no ( )
5. Did the medical condition occur on someone else's property yes ( ) no ( )
6. Have you retained an attorney to pursue personal damages yes ( ) no ( )

   If YES what is your attorney's name and telephone #

   _____

Your insurance contract may include a subrogation provision. Subrogation means your insurance makes any payments on your behalf for injuries caused by another party who may be liable for those injuries. Your insurance is entitled to recover those payments from the other party. As a condition of these payments, the subscriber agrees to cooperate with the medical insurance carrier in its efforts to recover the cost paid on behalf of the injured party.

I understand that if I or any of my dependents have been injured by another party, the benefits of my contract will be available to the injured person, subject to the exclusions and limitations of the contract. I agree to cooperation with my medical insurance carrier in its subrogation and reimbursement rights as stated in the contract. My medical insurance reserves the right to determine payment of attorney fees for recovery of its financial interest in this claim. I understand I am not entitled to keep that portion of the settlement which

represents reimbursement of the amount my medical insurance carrier paid towards my medical benefit except as determined by applicable law.

I hereby authorize my medical insurance (name listed below) and anyone acting on behalf of it, to release any information about my accident and the benefits and medical services I received in connection with my accident to any persons who may be liable to me or to my insurance company of any such person or to any insurance company that provides coverage for injuries related to this accident. I further authorize my insurance company to release any information concerning my coverage to my medical insurance carrier (name listed below).

I also authorize my medical insurance carrier to review any workers' compensation claims files pertaining to me so that my medical insurance carrier can determine whether workers' compensation coverage is available for any of my injuries.

I certify that the information on this form is true and accurate to the best of my knowledge

Subscriber signature **Date** **Social Security Number**

Address **Home Telephone number**

Medical insurance name

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