MEMBER ACCIDENT/INJURY REPORT

I. MEMBER INFORMATION

Member Name: _____

Member ID*: _____ Group ID*(*if applicable*):_____

Date of Birth:_____MM/DD/YYYY_____ Claim Number: _____

Info can be located on a member's health insurance I.D. card.

II. TYPE OF CLAIM

Was this claim the result of an accident and/or an injury? ☐ Yes ☐ No

If the answer to the question above is ***No****, skip to Section IV.*

III. CLAIM INFORMATION

Date of Service: _____MM/DD/YYYY_____ Date of Accident/Injury: _____MM/DD/YYYY_____

Describe how and where the accident/injury happened: _____

_____

_____

Was the accident/injury investigated by the police?

☐ Yes What agency? ☐ Police ☐ State Patrol ☐ Sheriff's Office ☐ Other
Please provide a copy of the police report along with this form.

☐ No

Did the accident/injury occur while on the job?

☐ Yes Was a worker's compensation claim filed?

☐ Yes Please supply a copy of the worker's compensation outcome; i.e. payment, settlement, denial, etc.

☐ No

If a worker's compensation claim was not filed, was it because of one of the following:

☐ Worker's compensation was waived
Please supply copy of WC-10.

☐ Member is self-employed
Please supply a copy of business license.

☐ Other _____

☐ No

Is there any other third party that is responsible for the payment of this accident/injury?

☐ Yes Please supply that information _____

☐ No

IV. SIGNATURE

By signing below, I certify the information provided on the form is true, accurate and complete.

☐ As an individual with the capacity to provide consent, my typed full name below constitutes my signature and is intended to be binding.

Signature of Member/Guardian: _____ Date: _____MM/DD/YYYY_____

For questions, contact Customer Service at (866) 403-2785.

Return this form to:
Alliant Health Plans | ATTN: Customer Service
P.O. Box 1128
Dalton, GA 30722
Email: accidentinjury@AlliantPlans.com
Fax: 866-634-8917