

410 Chickamauga Ave
Suite 301
Rossville, GA 30741



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ACCIDENT FORM

We have received a claim for treatment that may be the result of an accident or injury. Please provide the information requested below in regard to the claim in question. **Please correct any mistakes for information provided and be as specific as possible in answering. Failure to provide the information requested may cause your benefits to be suspended in accordance with the SPD.** Once this form is completed, please return it to NECA/IBEW FMCP, 410 Chickamauga Avenue, Suite 301, Rossville, GA 30741.

Member:	
Patient:	
Potential Accident Date?:	
Provider:	
Service Date:	

Please provide a phone number where you can be reached. _____

Was this condition being treated the result of an accident or injury? Yes _____ No _____ (if no, please briefly explain why medical service(s) was sought)

What was the date the accident or injury occurred?

If patient is an adult, is this condition a result of injury during the course of employment? Yes _____ No _____

How did the accident or injury occur?

Where did the accident or injury occur?

Do you feel that another party is responsible for this accident or injury? Yes _____ No _____

If Yes, please provide a brief description of that party's involvement in the accident or injury. (Attach a police report if applicable and feel free to continue on the reverse if necessary)

If Yes, please provide the name and complete contact information for this individual:

Are you pursuing reimbursement from another party or insurance carrier in relation to this injury? Yes_____ No_____

If known, please provide information on the responsible party's insurance carriers, including any claim numbers:

Have you hired an attorney? Yes_____ No_____

If yes, please give your attorney's name, address and phone number:

Has a **lawsuit** been filed? If so, state the court in which it was filed, the date of filing, and the court number:

If not, do you plan to file suit? Yes_____ No_____

If not, explain why you will not pursue a claim or suit:

Name, address, and policy number of all other insurance coverage you have:

Home:

Auto:

Other:

If you have already provided the information requested related to the above incident, we apologize but please provide the information requested related to the given accident and treatment dates. Use a separate sheet if necessary.

Member Signature

Date

PLEASE: Return this form to: NECA/IBEW FMCP 410 Chickamauga Avenue, Suite 301, Rossville, GA 30741.