410 Chickamauga Ave
Suite 301
Rossville, GA 30741

Family Medical Care Plan

Phone (706) 841-7000
Toll Free (877) 937-9602
Fax (706) 841-7020
www.nifmcp.com

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.