



Date: _____

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Re: Claim No: _____

Patient: _____

Group No: _____

MemberID#: _____

Date of Service: _____

A medical claim has been received in our office for the above named patient. This claim was submitted with an injury or accident diagnosis. In order to determine plan liability, you are required to provide written details regarding injury or accident related services. This information is used to determine the possibility of a third party liability. The information you submit becomes a legal document to this file.

If the injury was incurred due to an auto accident, you must provide a copy of the police report. Please advise whether or not your auto policy includes medical coverage.

The claim was submitted by MEDICAL NETWORK for: _____

Please answer the following questions and return the signed document to us within 30 days. Failure to respond within the 30 days will result in denial of all claims related to this diagnosis.

HOW DID THIS OCCUR: _____

(If there was no specific accident/ injury related to this diagnosis, please write "no known injury".) WHERE WERE YOU WHEN IT HAPPENED: (i.e., home, work, school, auto, other)? _____

DATE OF THE INCIDENT: _____

If another person is responsible for the injury/ condition, please complete the following:

NAME: _____

ADDRESS: _____

INSURANCE COMPANY (i.e., auto, workcomp, other) _____



PAGE NO: 2

INS. CO ADDRESS & PHONE #: _____

INS. CLAIM#: _____

HAVE YOU OR ARE YOU HIRING AN ATTORNEY? _____

ATTORNEY NAME, ADDRESS, PHONE#: _____

HAS CASE BEEN SETTLED? _____

SIGNED BY: _____

DATE SIGNED: _____

Thank you for your prompt response.

Sincerely,

Debbi Hanners, Manager
Claims, Enrollment, & Support

cc: MEDICAL NETWORK