

## 1 Universal injury or accident statement

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Today's Date \_\_\_\_\_

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Date of injury \_\_\_\_\_ Place where injury occurred (work, home, parking lot, car, friend's house, etc.) \_\_\_\_\_

## 2 Please describe how the injury or accident occurred

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 3 Work related injury

Yes  No (If yes, complete this section)

Was the injury work related?

Name of Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Workman's Compensation Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 4 Third party liability settlement

Yes  No (If yes, complete this section)

Is there a possible third party liability settlement? (e.g., auto, homeowners, property)

Name of Insurance \_\_\_\_\_ Telephone \_\_\_\_\_

Adjuster's Name (if known) \_\_\_\_\_ Telephone \_\_\_\_\_

## 5 Authorization

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

\_\_\_\_\_  
 Patient's Signature (or responsible party if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_