CONSOCIATE HEALTH

Possible Injury Information Form

Policy Member (Please Print Name): _____

Patient Name (if different than member): _____

Policy ID #: _____

Claims pending for (which member of the family) _____

Dear Policy Member:
The diagnosis on the claim listed below indicates the possibility of an injury. In order to accurately process the claims for the above referenced patient, we need additional information. Please take a few moments to answer the following questions so we may give you the maximum possible benefits of your policy.

Date of service(s): _____

1. Were the above services required due to an accident or injury? ○ Yes ○ No
2. Did the accident or injury arise out of or in the course of employment? ○ Yes ○ No
3. On what date did the accident or injury occur? _____
4. Where did the accident or injury take place? ○ Home ○ Auto ○ Work ○ Other
5. Were the above services required due to a work related sickness? ○ Yes ○ No
6. Please describe how the accident or injury occurred? _____

_____

_____

7. Did you purchase insurance through the patient's school (if your child was injured while on school property or while participating in a school sport)? ○ Yes ○ No

The information above is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

RELEASE OF INFORMATION:
To all physicians, hospitals, clinics, dispensaries, sanitariums, druggists, and all other agencies (including other insurance companies), you are authorized to permit Consociate or its representatives to obtain or view a copy of your records pertaining to my examination, treatment, history, prescriptions and medical expenses.

Signature: _____ Date: _____

If you have any questions please contact our customer care department.
Our office hours are Monday-Friday 8:00 a.m. – 5:00 p.m.
Thank you for your cooperation. Claims Department