Date:

Patient Name:
Member ID:
Date of Service:
Provider Name:

Please mail this completed form to PO Box 9 Klamath Falls, Or 97603 or FAX the completed form to (541) 882-1447.
Please answer all questions to the best of your knowledge to ensure claims are processed correctly.

1. **Is the above condition related to an accident or injury?** ☐ **Yes** ☐ **No**

   IF "NO", please explain below, then sign, date and return this form. **IF "YES"** proceed to number 2, below.

   _____

   _____

   _____

2. **If "YES" – Please complete the following:**

   Date of Accident/Injury: _____ Where did the accident occur? _____

   How did the accident occur? _____

   _____

   _____

   a) Is another party responsible for the accident/injury? ..... ☐ Yes ☐ No
   b) Was this work-related? ..... ☐ Yes ☐ No
   c) Did the accident/injury occur in a private residence, other than at your home? ..... ☐ Yes ☐ No
   d) Did the accident/injury occur in or around an automobile? ..... ☐ Yes ☐ No
   e) Have you or do you intend to file any legal action for this accident/injury? ..... ☐ Yes ☐ No
   f) Was a police report prepared for this accident/injury? ..... ☐ Yes ☐ No
   g) Have you received any payment(s) from the responsible party or their insurance carrier? ..... ☐ Yes ☐ No

NOTE: ALL questions answered "YES" above must have number 3 completed (below) then sign, date and return this form.

3. ***Name and address*** **of responsible party, employer, homeowner, auto insurance carrier, attorney, police department or party that you have received payment from as referenced above in Question Number 2:**

   Name: _____ Policy or Ref. Number: _____

   Address: _____

   Phone#: _____ Adjuster's Name: _____

_____ _____ _____

Enrollee/Policyholder Signature Telephone Number Date