

ALLIED

Benefit Systems, Inc.

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ADMINISTRATORS AND CONSULTANTS

Accident Information Verification Form

Employee:	_____
Insured's SS#:	_____
Patient:	_____
Claim #	_____
<small>Can be any pended/denied clm number for the patient</small>	
Group #	_____

Denied Information Received

Missed Releases

First time receiving information

Date: _____

Caller: _____

Insured's Name: _____

Group Name: _____

Member's phone: _____

We are in receipt of claims for the above named patient. Please furnish us with the following information:

Are charges incurred due to an injury? Yes No

If YES, date of injury: _____ Place of injury: _____

Describe how and where injury occurred?

Is this work related? Yes No

Was injury due to auto accident? Yes No

Is there any Third Party Liability Insurance? Yes No

If yes, please submit the name and address of the other insurance:

If this was not an injury, was this condition gradual? Yes No