Accident or Injury Information Verification Form

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Employer Name	Group Number
Employee Name	**Employee UID**
Employee Phone Number	**Patient Name**
Provider Name	**Claim #**

Allied Benefit Systems, Inc. is the claims processor for the employer group health plan ("Plan"). You are receiving this questionnaire because the above-referenced claim was submitted to the Plan. The preliminary information indicates the patient may have received healthcare services related to an accident or injury. To enable the Plan to process this claim, additional information is required. If you have previously completed a similar questionnaire for a related claim, please disregard this form. Otherwise, please complete the questions below.

Was the above-referenced claim the result of an accident or injury?

- ☐ No. If no, please sign, date and return this questionnaire to Allied Benefit Systems, Inc.
- ☐ Yes. If yes, please complete all the fields pertaining to the accident.

Date of Accident or Injury	Place of Accident or Injury

Please describe how the accident or injury occurred

Is this accident or injury covered by other insurance?

- ☐ No. If no, please sign, date and return this questionnaire to Allied Benefit Systems, Inc.
- ☐ Yes. If yes, please complete all the fields pertaining to the accident.

Type of Other Insurance:

- ☐ Workers' Compensation
- ☐ Property
- ☐ Homeowner's
- ☐ Automobile
- ☐ Other:

Signature _____ Date _____

Please return this questionnaire to the address shown above. Otherwise, the Plan will deny the claim. Please note the submission of the requested information does not guarantee payment, but rather allows the Plan to continue to process the claim.