Allied

Administrators and Consultants
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Accident Information Verification Form

Employee: ______________________

Insured's SS#: ______________________

Patient: ______________________

Claim #: ______________________
Can be any pended/denied claim number for the patient

Group #: ______________________

Date: ______________________

Insured's Name: ______________________

Group Name: ______________________

Member's Phone: ______________________

Dear Mr./Mrs. ______________________

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

Are the 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 other insurance:

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

Notes:

Office Use Only

☐ Denied Information Received

☐ Missed Releases

☐ First time Receiving Information

CSR: ______________________

Adjusters initials: ______________________

Caller: ______________________

Caller's #: ______________________