



**ACCIDENT MEDICAL CLAIM FORM**

**TO BE COMPLETED BY INSURED MEMBER**

Policy/Plan Number: \_\_\_\_\_

Name of Injured Member: \_\_\_\_\_ Alternate Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Patient's Name and Relationship (If other than Insured Member): \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female

1. Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 1a. Hour: \_\_\_\_ : \_\_\_\_  AM  PM

2. Description of Accident  
 A) How did it occur? \_\_\_\_\_  
 \_\_\_\_\_

B) Where did it occur? City: \_\_\_\_\_ State: \_\_\_\_\_ Location: \_\_\_\_\_

C) Nature of Injury: \_\_\_\_\_

3. Were you hospitalized?  Yes  No

3a. If yes, please give Name and Address of Hospital: \_\_\_\_\_

4. Did this accident occur while playing in an Organized Sport?  Yes  No

5. Was this a work related accident/injury?  Yes  No

5a. If yes, has this been filed with Worker's Compensation?  Yes  No

6. Have you ever had this Condition before?  Yes  No

6a. If yes, please give month, date and year: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

7. Is the Patient covered by any other plan for expenses related to this accident?  Yes  No

7a. If yes, please give the following information of the Insurance Carrier:  
 Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Policy Number \_\_\_\_\_

Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Termination Date (if applicable): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE NOTE: Incomplete claim forms will result in process delay.**

I understand that this information will be used by Dr. Louis Clarizio for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Member Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**REVIEWED**  \_\_\_\_\_