



PO Box 709718  
Sandy, UT 84070-9718  
Customer Service 844-234-4472

Member Name: (print) _____		Claim #: _____		Member ID#: _____	
<b>Was the treatment in question a result of one of the following:</b> <b>Date of Injury:</b> _____					
<input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Injured at patient's home <input type="checkbox"/> Injured on someone else's property <input type="checkbox"/> Injured at work <input type="checkbox"/> Other					
<b>Please briefly describe what happened or lead to the accident or injury:</b>					
<b>Motor Vehicle Accident</b> (Auto, Motorcycle, Boat or ATV)	Patient was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motorcyclist				
	State accident or injury occurred: _____				
	List all family members involved: _____				
	Auto Insurance Carrier: _____		Claim/Policy: _____		
	Adjusters Name: _____		Phone: _____		
	Other Party's Insurance Carrier: _____		Claim/Policy: _____		
Adjusters Name: _____		Phone: _____			
<b>Injury was Work Related</b>	Employers Name: _____		Phone: _____		
	Work Comp Insurance Carrier: _____		Phone: _____		
	Adjusters Name: _____		Phone: _____		
<b>Injury Occurred on Someone Else's Property</b>	Name of Other Party: _____				
	Other Party's Address: _____				
	City: _____		State: _____	Zip Code: _____	
	Their Insurance Carrier: _____		Claim #: _____		
	Adjusters Name: _____		Phone: _____		
<b>Attorney Information</b>	Are you pursuing a personal injury claim: <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Attorney Name: _____		Phone: _____		
	Law Firm Name: _____				
	Has the Claim been Settled: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date Settled: _____				
	With whom did you settle: _____				
<b>The above information is true and correct to the best of my knowledge:</b>					
Member Signature: _____		Date: _____			

Please Mail Form to: PO BOX 709718 Sandy, UT 84070 or Fax to: 844-533-1289.