Accident Form

motivhealth®

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

Member Name: (print)	Claim #:	Member ID#:

Was the treatment in question a result of one of the following: **Date of Injury:** _____

☐ Motor Vehicle Accident ☐ Injured at patient's home ☐ Injured on someone else's property
☐ Injured at work ☐ Other

Please briefly describe what happened or lead to the accident or injury:

Motor Vehicle Accident (Auto, Motorcycle, Boat or ATV)	**Patient was:** ☐ **Driver** ☐ **Passenger** ☐ **Pedestrian** ☐ **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:** _____
Injury was Work Related	**Employers Name:** _____ **Phone:** _____ **Work Comp Insurance Carrier:** _____ **Phone:** _____ **Adjusters Name:** _____ **Phone:** _____
Injury Occurred on Someone Else's Property	**Name of Other Party:** _____ **Other Party's Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Their Insurance Carrier:** _____ **Claim #:** _____ **Adjusters Name:** _____ **Phone:** _____
Attorney Information	**Are you pursuing a personal injury claim:** ☐ **Yes** ☐ **No** **Attorney Name:** _____ **Phone:** _____ **Law Firm Name:** _____ **Has the Claim been Settled:** ☐ **Yes** ☐ **No** **Date Settled:** _____ **With whom did you settle:** _____

The above information is true and correct to the best of my knowledge:

Member Signature: _____ **Date:** _____

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