

Request for Medical Claim Information



PO BOX 709718
Sandy, UT 84070-9718
Customer Service: 1-844-234-4472

Date: _____

Member Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Dear MotivMember,

At MotivHealth Insurance, we are committed to keeping your health care costs as affordable as possible. To do this, we evaluate every claim received and determine if the billed services are our responsibility or should be paid by another party.

Recently, we attempted to process billed charges for medical services you received. However, we were unable to determine whether this treatment was the result of an accident or injury for which another party may be responsible.

To assist us in this process, please take a few moments to answer the attached questionnaire as accurately and completely as possible. From the date of this letter, you will have 30 days to return this form to us for further review. Should you have any questions concerning this request, please contact a personal health assistant at 1-844-234-4472.

We thank you for your assistance regarding this matter.

Sincerely,

Your Dedicated MotivHealth Insurance Team

Accident Form



PO BOX 709718
Sandy, UT 84070-9718
Customer Service: 1-844-234-4472

Member Name: _____	Claim #: _____	Member ID #: _____
<p>Was the treatment in question a result of one of the following? Date of Injury: _____</p> <p> <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 </p> <p>Please briefly describe what happened or led to the accident or injury: _____</p> <p>_____</p> <p>_____</p>		
<p>Motor Vehicle Accident (Auto, Motorcycle, Boat, or ATV)</p>	<p>Patient was: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motorcyclist</p> <p>State in which accident/injury occurred: _____</p> <p>List all family members involved: _____</p> <p>Auto Insurance Carrier: _____ Claim/Policy: _____</p> <p>Adjuster's Name: _____ Phone: _____</p> <p>Other Party's Insurance Carrier: _____ Claim/Policy: _____</p> <p>Adjuster's Name: _____ Phone: _____</p>	
<p>Work-Related Injury</p>	<p>Employer's Name: _____ Phone: _____</p> <p>Work comp Insurance Carrier: _____ Phone: _____</p> <p>Adjuster's Name: _____ Phone: _____</p>	
<p>Injury Occurred on Someone Else's Property</p>	<p>Name of Other Party: _____</p> <p>Other Party's Street Address: _____</p> <p>City: _____ State: _____ ZIP: _____</p> <p>Their Insurance Carrier: _____ Claim #: _____</p> <p>Adjuster's Name: _____ Phone: _____</p>	
<p>Attorney Information</p>	<p>Are you pursuing a personal injury claim? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attorney Name: _____ Phone: _____</p> <p>Law Firm Name: _____</p> <p>Has the claim been settled?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Settled: _____</p> <p>With whom did you settle: _____</p>	

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.

