Acclaim Inc.
808 Varsity Drive
Tupelo, MS 38801

DATE:

Patient Name:
Patient ID
Date of Service:
Provider/Clinic Name:
Employee Name:
Employee ID
Group Health Plan:

RE: Accident or Injury Claim(s)

PATIENT NAME AND ADDRESS

Acclaim, Inc. received a claim or claims for medical services provided to the above referenced patient. Before the claim(s) can be processed, additional information is needed from you because your group health plan has an accident or injury provision that will not pay if there are third party payor sources.

Under the accident or injury provision of your Group Health Plan, Acclaim must verify the following information:

1. Whether or not the condition for which you received medical treatment may have been caused by a third party (i.e., another person, a product or a property hazard) or
2. If you received or will receive a monetary settlement from the responsible third party or
3. If you made a claim or filed a lawsuit against a third party for the injury you sustained.

If you received or will receive a monetary settlement or judgement due to the accident or injury, your Group Health Plan is entitled to be reimbursed for any medical expenses paid on you behalf.

For Acclaim to efficiently process your claim(s) quickly and correctly we need your assistance. Please complete the portion(s) of the form that apply to the above referenced patient. Place the completed forms in an envelope and return to Acclaim within fourteen days from the date of this letter. CLAIMS WILL BE PENDED UNTIL THE RECEIPT OF THE FORM(S).

If you have any questions about this letter or the attached form(s), please call our Customer Service Department at 1-800-317-2324. Our business hours are Monday-Friday from 8:00 a.m. to 4:30 p.m., except during holidays.

Thank you for your cooperation.

Acclaim Customer Service Department
1-800-317-2324

Acclaim Inc.
Accident/Injury Illness Questionnaire

Patient Name:
Patient ID No.:
Date of Service:
Provider/Clinic Name:
Employee Name:
Employee ID No.:
Group Health Plan:

COMPLETE ONLY THE PORTIONS OF THIS FORM THAT ARE APPLICABLE TO THE REFERENCED PATIENT/MEMBER.

1. Briefly describe the nature of the injury or illness. _____
_____

2. Date and place of the accident._____
_____

3. Do you believe any person, product or property caused or contributed to the accident/injury or illness?

_____Yes (Answer 3A and 3B) _____No (Go to Question 4.)

3a. State the other party's name, address and phone number.
Name_____ Phone Number_____
Address_____ City/State/Zip_____

3b. Does the other party have insurance coverage?
_____Yes _____No (Go to Question 4.)

Name of insurance company or carrier_____
Insurance company's address_____
Insurance company's phone number_____
Name of policy holder_____Policy Number_____
Policy holder's address_____Phone No._____
Claim Adjuster's name_____Claim No._____

4. Do you have other personal insurance coverage?
_____Yes _____No (Go to Question 5.)

Name of insurance company or carrier_____
Insurance company's address_____
Insurance company's phone number_____
Name of policy holder_____Policy Number_____
Policy holder's address_____Phone No._____
Claim Adjuster's name_____Claim No._____

5. Did you report this accident/injury to the police: _____Yes _____No
If yes, attach a copy of the police accident report. The report must indicate any violations given and the name of the third party.

6. Have you retained and attorney? _____Yes _____No (Go to Question 7)
6a. Name of attorney_____
Attorney's address_____Phone No._____
6b. Have you or do you intend to file suit? _____Yes No_____

7. Have you received a monetary settlement from this accident or incident?
_____Yes _____No (Go to Question 8)
If yes, please provide the following information:

Amount of Settlement_____

Name, address and phone no. of person or company who paid the settlement:

_____
_____
_____
_____

8. To the best of my knowledge, this accident/injury/illness was not caused by another person, product or property.

Patient Signature (if not a minor child)_____
Employee's Signature_____
Date_____

IF A THIRD PARTY WAS INVOLVED IN THE ACCIDENT/INJURY/ILLNESS, PLEASE COMPLETE AND HAVE ACKNOWLEDGEMENT OF SUBROGATION PORTION OF THE FORM NOTARIZED.

ACKNOWLEDGEMENT OF SUBROGATION

I,_____, understand the subrogation provision of the health plan in which I participate. The intent of the subrogation provision of the Group Health Plan is to exclude benefits for services for any injury to the employee or enrolled dependent for which another party or someone else, on his or her behalf, makes settlement or is legally responsible. In consideration of the Group Health Plan's payment of claims, which may be excluded by the subrogation provision, I hereby agree to set over and assign to the Group Health Plan any and all sums that may be collected as a result of any settelment or suits against a third party responsible for the accident in question, up to but not exceeding the amount paid by the Group Health Plan in satisfaction of medical bills incurred by the patient, _____ as a result of the said accident.

_____ _____
Signature of Patient or Parent or legal guardian, if a minor — Date

Sworn to and subscribed before me, a Notary Puplic, by _____
on this _____day of _____, 20____.

Seal

_____
Notary Public

Return to : Acclaim, Inc.
808 Varsity Drive
Tupelo, MS 38801