WMI TPA

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ACCIDENTAL INJURY INFORMATION REQUEST

The following information is necessary in order to accurately process a claim that has been received. Attach additional sheets if needed.

Name of Employee _____ Employee SSN _____

Name of Patient _____ Patient's Date of Birth _____

Employee's Address _____ Phone No. _____
Street City State Zip

Are the services on this claim the result of an accidental injury? _____ Yes _____ No

If yes, please indicate the **date** that the accidental injury occurred. _____

If yes, please describe the exact details of **how and where** the accidental injury happened (if additional space is required, please use the reverse side of this form): _____

1. Did the accidental injury involve a motor vehicle? _____ If yes, please provide the name of the motor vehicle insurance carrier, along with the name, address and phone number of any other persons involved: _____

   a) Was a police report filed? _____ If yes, with what agency? _____
2. Did the accidental injury occur on private property? _____ If yes, please provide the name of the property owner and the property address: _____
3. Was the accidental injury work related? _____
4. Will a claim be filed with a third party or another insurance company? _____ If yes, please provide the name, address and phone number of the company: _____
5. Will the injured party be represented by legal counsel? _____ If yes, please provide the name, address, and phone number of the attorney. _____

Your plan contains a right of reimbursement and subrogation which assigns, subject to certain limitations and to the extent of any payments by the plan, any claim that the insured has, may have, or shall have against any third party. Your plan also provides for a right to reimbursement from the proceeds of any settlement or judgment that might result from the exercise of such claims by the insured person. The plan may pursue the insured person's claims against any person or entity to the extent of its payments. The insured person shall not discharge any claim against any person or entity without the express written permission of an authorized plan representative, and the insured person shall fully cooperate with the company in pursuing its right of reimbursement, including, but not limited to, providing us with information in the insured's possession and giving testimony.

_____ _____
Signature of Patient or Parent **Date**

The submission of fraudulent claims or false or misleading information may subject the person who provides the fraudulent information to fines and/or imprisonment, pursuant to state and federal laws.