

Accident/Injury Report Form

UPREHS Medicare Plans
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax number: 801-595-2039

The information provided by you in this report is confidential and will not be released to anyone without a signed authorization from you, with the exception of Federal or State law requirements. We are required to obtain this information from you by Federal Medicare law to coordinate your benefits.

Instructions

Complete the requested information below, sign, and date the form, and return it to UPREHS at the address above. This completed form must be signed and returned to UPREHS before claims can be considered for payment.

Member Name _____ Phone (____) _____

UPREHS ID Card # _____ Medicare # _____

Street Address _____

City, State, Zip _____

I was not injured. Describe below the medical condition for which you were treated, including date of onset or initial treatment. _____

I was injured at work. Date of the injury _____ Where are you working? _____
Describe below the accident and the part(s) of your body that were injured. _____

I was injured but not at work. Date of the injury _____ Place of the injury _____
Describe below the accident, the place where you were injured, and the part(s) of your body that were injured. _____

I was injured in an auto accident. Date of the accident _____ Was a police report filed? ____
If yes, please provide auto insurance information

(Name of auto insurance company, policy number, and claim number, if applicable.)

If another party or person was responsible for the accident, provide their name, address, and telephone number. If you have retained an attorney, please note attorney information on the back of this form. Describe below the accident and the part(s) of your body that were injured.

Describe the injury or medical condition below. If additional space is needed, use the back of this form.

Member Signature _____ Date _____

To the best of my knowledge, the information provided is correct.

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