CONCIERGE
Third Party Administrator

PO Box 4070
Bartlesville, Oklahoma 74006
Phone: 888-820-5687 / Fax: 918-333-9505

Accidental Injury Information Request

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Regarding: _____

Date of Injury: _____

Group Number: _____

Type of Injury: _____

Before we can complete the processing of your claim for the above date of accident / injury, we must have answers to the following questions:

Was this visit initiated by an accident or injury? **If no, check here ☐ sign and return.**

Where did the accident / injury occur?

_____

Please give a brief description of the accident / injury.

_____

Who, if anyone, was at fault in the accident / injury?

_____

Are there any expenses for which this / these claims are covered by any other insurance or third party?

Yes ☐ No ☐ Workers Comp. ☐

Sincerely,
Concierge

The statements above are true and correct to the best of my belief. I authorize any hospital, physician or health care provider to furnish any information requested.

_____ _____

Employee / Patient Signature Date