MEMBER ACCIDENT/INJURY REPORT

I. MEMBER INFORMATION

Member Name: _____

Member ID*: _____ Group ID*(*if applicable*):_____

Date of Birth:_____MM/DD/YYYY_____ Claim Number: _____

***Info can be located on a member's health insurance I.D. card.**

II. TYPE OF CLAIM

Was this claim the result of an accident and/or an injury? ☐ Yes ☐ No

*If the answer to the question above is **No**, skip to Section IV.*

III. CLAIM INFORMATION

Date of Service: _____MM/DD/YYYY_____ Date of Accident/Injury: _____MM/DD/YYYY_____

Describe how the accident/injury happened: _____

_____

_____

Did the accident/injury occur while on the job? ☐ Yes ☐ No

Describe where the accident/injury occured: _____

_____

Was the accident/injury investigated by the police? ☐ Yes ☐ No

If yes, what agency? ☐ Police ☐ State Patrol ☐ Sheriff's Office

***Please provide a copy of the police report along with this form** (if applicable and available)**.**

Member's job title(s): _____

Provide brief description of member's job duties: _____

_____

Has the member's worker's compensation coverage been waived. ☐ Yes ☐ No

If yes, please submit copy of WC-10 form.

IV. SIGNATURE

By signing below, I certify the information provided on the form is true, accurate and complete.

Signature of Member/Guardian: _____ Date: _____MM/DD/YYYY_____

For questions, contact Customer Service at (800) 811-4793.

Return this form to:
Alliant Health Plans | ATTN: Claims Department
P.O. Box 3728
Corpus Christi, TX 78463
Email: customerservice@AlliantPlans.com