Employee/Policyholder Name:

Employer:

Patient name:

Relationship:

Dear Employee:

This form can be used to provide your response to a claim that is pended/denied due to a possible accident or injury.

Date of Service: ___________________________________
Provider/Physician: ________________________________

( ) NO   This claim is **not** related to an auto/vehicle accident, work-related accident, or any other party liability. ***Sign, date, and return the form.***

( ) YES This claim is related to an auto/vehicle accident, work-related accident, or other party liability.

* Details: What prompted you to seek treatment?

____
____
____

If YES, select the response that applies:
( ) This claim is related to an auto/vehicle accident.
( ) This claim is work-related.
( ) A third party is liable for this claim. ( ) Third Party   ( ) Homeowner

LIABLE PARTY NAME, AUTO, OR HOMEOWNER INS:____
Address:____

*Employee Signature: ______________________________   *Date: _______________________

*Phone Number: __________________________________

Return your form to us by mail, fax, or web portal.
Upload to website: integratpa.com,
'Contact Us', 'Customer Service/ShareFile'
Fax: 302-629-8416