INTEGRA Administrative Group

Employee/Policyholder Name:

Employer:

Patient name:

Relationship:

This form can be used to provide your response to a claim that is denied because the diagnosis may indicate a possible accident or injury. Please answer all questions below:

Date of service or appointment date:

Provider/Physician:

Details:_____

_____

_____

Is this claim related to an auto or vehicle accident?	NO	YES**
Is this claim work-related?	NO	YES
Did accident/injury occur on property/premise other than your home?	NO	YES
Is there another party liable for this claim?	NO	YES**

** IF YES: LIABLE PARTY NAME or AUTO INSURANCE: _____

Address: _____

Employee Signature: _____ Date: _____

Phone Number: _____

FAX to: 302-629-8416

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