**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:**

**You must provide details for claim consideration. What prompted you to seek treatment?**

_____

_____

_____

| | | |
|---|---|---|
| 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

110 South Shipley Street Seaford DE 19973 800-959-3518 www.integratpa.com