



NEW WEST HEALTH SERVICES

and New West Health Plan

ACCIDENT REPORT

Member ID:
Policyholder's Name:
Patient's Name:

Date of Service:
Provider:
Claim Number:

We Cannot Process Your Claim Without This Information. Please Be Advised That Failure To Return This Accident Report Within Forty-Five (45) Days Will Result In Denial Of The Claim.

If the box below is NOT applicable to you, → Go to Part 1.

Check here only if applicable:

- I am not and do not expect to request reimbursement or compensation for the above date of service from any person or entity and my injuries are NOT work related. I agree to promptly notify New West Health Services (New West) if this changes and I acknowledge that I may be required to complete this Accident Form at that time. → **Go to Part 5, sign and return.**

Part 1: General Information *(legibly print responses)*

- Date of accident, injury or condition onset: _____

- Place of accident, injury or situation that caused condition: Home Work Other: _____

- Names of other family members or other people involved in the accident/incident: _____

- Please describe how the accident, injury or condition occurred, and describe your injuries: _____

- Have you hired an attorney to represent you as a result of this accident, injury, or condition: Yes No
If you marked "Yes," provide the name address and telephone number of your attorney.
Name: _____
Address: _____
Telephone #: _____

- Was the incident/accident work related:
 Yes No → *If you marked "Yes" to this question, please Go to Part 2.*
- Was the incident/accident related to an automobile accident: Yes No → *If you marked "Yes" to this question, please SKIP to Part 3.*
→ *If you marked "No" to this question, please SKIP to Part 4.*

Part 2: Work Related

- Are you self-employed or a sole proprietor?
 Yes No If you marked "Yes," enclose a copy of the exemption form or other verification.
- Have you notified your employer of this accident, injury or condition? Yes No
- Have you filed a claim for benefits under Workers' Compensation or similar laws? Yes No
- Name of Employer: _____

- Employer's Workers' Compensation Carrier's Information:
Name: _____
Address: _____

Telephone #: _____
Claim or Case Number: _____
→ *If your work related accident involved a vehicle accident, please continue to Part 3.*
→ *If your work related accident did not involve a vehicle, SKIP to Part 4.*

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Part 3: Vehicle Related Accident/Incident Information

- 1. Was the Patient a Passenger Pedestrian
 Driver Other: _____
- 2. Was a police report filed?
 Yes No *☰ If you marked "Yes," attach a copy of the police report to this Accident Report.*
- 3. Is there medical coverage available through your automobile policy? Yes No
- 4. Have you reported this accident to your insurance carrier? Yes No
- 5. What are your automobile insurance policy limits:
\$ _____
☰ Attach a copy of the insurance declaration sheet to this Accident Report.
- 6. Is another party liable/responsible for this accident, injury or condition? Yes No

If you marked "Yes," please complete the following:

- a) Liable/Responsible Party(ies) Name(s): _____

- b) Is there medical/insurance coverage available through another party that was involved in the accident?
 Yes No
- c) If you marked "Yes" above: What is the name and address of the Policyholder:
Name: _____
Address: _____

- d) What are the policy limits? \$ _____

*☰ Attach a copy of the insurance declaration sheet to this Accident Report, OR if not available, the name, address and policy number of the insurance company.
➔ Go to Part 5 (SKIP Part 4).*

Part 4: Other Accidents/Incidents

(i.e., property, product, negligence)

- 1. If this accident occurred at a:
 Business Residence Public Place
What is the name and address of the Property Owner:
Name: _____
Address: _____

- 2. Is another party liable/responsible for this accident, injury or condition?
 Yes No ➔ *If you marked "Yes" please complete the following questions:*
 - a) Liable/Responsible Party(ies) Name(s): _____

 - b) Is there medical/insurance coverage available through another party? Yes No
☞ If you marked "Yes" above: What is the name and address of the Policyholder: _____

 - d) What are the policy limits? \$ _____
*☰ Attach a copy of the insurance declaration sheet to this Accident Report, OR if not available, the name, address and policy number of the insurance company.
➔ Go to Part 5.*

Thank you for your assistance!!

Part 5: Acknowledgement and Signature

The above information is true and accurate to the best of my knowledge.

(Patient's Signature or Signature of Parent or Legal Guardian)

Date: _____

(Relationship to Patient – i.e., self, mother, father, etc.)

Remember to enclose Requested Documents *☰*.