CIMISURGICAL
PLASTIC & RECONSTRUCTIVE SURGERY

Accident/Injury Insurance Report Form

PLEASE COMPLETE THE FOLLOWING STATEMENT. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS, AND THIS MAY BE FORWARDED WITH YOUR INSURANCE CLAIMS OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM. PLEASE COMPLETE THE SECTION THAT APPLIES TO YOUR INJURY AND SIGN AT THE BOTTOM OF THE FORM.

Last Name: _____ First Name: _____
Date of Injury: _____

Please describe how the injury or accident occurred:
_____
_____
_____

Work Related Injury

Name of Employer: _____
Telephone #: _____
Employer's Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____
Claim Address: _____
City: _____ State: _____ Zip Code: _____

Third Party Liability Settlement (Auto, Homeowner, and Property)

Name of Insurance: _____
Adjuster's Telephone #: _____
Adjuster's Name: _____
Claim #: _____

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to any insurance carrier if they request and additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for medical charges.

Patient Signature: _____ Date: _____