BAC of MICHIGAN
Health and Welfare Fund

P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

ID# _____ Date of Service _____

Member_____ Adjuster_____

Provider_____ Claim #_____

Patient_____

The following information is needed before we can process this claim. Consideration of the charges below cannot be made without the following information:

CLAIM REPORT

1) DATE INJURY OR ACCIDENT OCCURRED: _____

2) NATURE OF INJURY OR ACCIDENT: _____

_____

3) IF INJURY, HOW AND WHERE DID INJURY OCCUR? _____

_____

_____

4) WAS INJURY JOB-RELATED? _____

5) IS CLAIM BEING MADE FOR WORKMENS COMP? _____

6) WAS CLAIM AUTO-RELATED? _____
(motorcycle, boat, snowmobile, ATV…etc)

7) IS THERE A THIRD PARTY LIABILITY INVOLVED? _____

Upon receipt of this completed letter, your claim will receive our immediate attention.

Sincerely,

Claims Department