Important Benefit Information

PATIENT:
EMPLOYEE:
PROVIDER:

AMOUNT
CLAIM NO:
INCURRED:
GROUP NO:

**PLEASE RETURN THIS FORM TO:**
**FAX #: 925-297-6655**
**EMAIL ADDRESS: staff@IUPATWesternBenefits.org**
**LOG IN TO: www.iupatwesternbenefits.org, click on Member Benefits and Documents to Submit**
**MAIL: PO Box 58830, Tukwila, WA 98138**

Our records indicate that you received treatment for services that may be related to an accident or injury. The following information must be filled out completely and returned to the Claims Department before the related claims may be processed. Additional documents may be required.

**REMINDER: If this form is not fully completed and returned within 45 days, all related claims will be denied.

Please describe in full detail how and when you were injured, what injuries you sustained, where the incident occurred (home/work/auto, etc.), and if anyone else was involved in this incident.

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Please provide the name, address and phone number of any Third Party insurer involved with this incident such as (Worker's Compensation, Automobile Insurance, Home Owners Insurance etc.).

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Do you intend to file a claim because someone else is liable? If so, please indicate the name, address and phone number for your attorney:

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If the accident involves any type of off road vehicle please send us a copy of the vehicle registration.

Please include a copy of the police report if available. If a Third Party insurer has already made payment for any claims related to this accident, please provide a copy of their explanation ofbenefits.

Signature _____ Date _____

Sincerely,

Claims Department