Insurance Claimant Intake Form

Insurance Company: _____

Insurance Company #: _____ Ext._____

Claim Adjuster's Name: _____

Claim Adjuster's #: _____ Ext. _____

Insurance Company's Address:

_____

Insurance Company's Billing Address:

_____

Date of Incident: _____ Group #: _____

Claim/ Policy #: _____ Referred by:_____

SSN: _____

Physician: _____ Phone:_____

Address: _____

Attorney: _____ Phone: _____

Address: _____

Employer: _____

Company: _____ Phone: _____

Supervisor (Name and Title): _____

Address: _____

Was this case related to __ Work __ Auto __ Personal Injury

Explain: _____

How did the injury occur?

_____

_____

Did the injury occur at work?	__ Yes __No
If work related, are you working for the same employer?	__ Yes __No
If yes, was the employer notified?	__ Yes __No
Has the insurance company been notified?	__ Yes __No
Are you currently employed?	__ Yes __No

Occupation: _____

Are you currently under the care of a physician? __ Yes __No

Have you ever been treated for the same condition? __ Yes __No

When and by whom? _____

Were you admitted to the hospital? __ Yes __No

Do you have any pre-existing conditions related to this present injury? __ Yes __ No

If yes, please explain:

_____

_____

How will payment be made?

__ Auto Insurance ___Workers' Compensation ___Personal Injury Insurance __Attorney Lien