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ABOUT SSL CERTIFICATES



Accident Information Form

Items with blue dots are required fields. Please complete as many of the remaining fields as possible, so that we may properly assist you. Should you require assistance in completing this form, please contact a ClaimAssist representative at 800-875-5808.



Hospital Name: = required

Hospital Account #:

Patient Information

Patient Name

Social Security - -

Address:

City/State/Zip , -

Home Telephone - -

Work Telephone - - ext.

Email Address:

Date of Accident / /

Date of Emergency Room Visit / /

Patient has Attorney Yes No

Health Insurance Information

Insurance Company

Address

City/State/Zip , -

Policy Holder

Plan Number

Policy Number

☛ Patient's injury was the result of:

- Motor Vehicle Accident
 Workers Compensation

- General Liability (Slip and fall, Dog bite, etc.)
- Other

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