# Request for Medical Claim Information

motivhealth®

PO BOX 709718
Sandy, UT 84070-9718
Customer Service: 1-844-234-4472

Date: _____

Member Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Dear MotivMember,

At MotivHealth Insurance, we are committed to keeping your health care costs as affordable as possible. To do this, we evaluate every claim received and determine if the billed services are our responsibility or should be paid by another party.
Recently, we attempted to process billed charges for medical services you received. However, we were unable to determine whether this treatment was the result of an accident or injury for which another party may be responsible.

To assist us in this process, please take a few moments to answer the attached questionnaire as accurately and completely as possible. From the date of this letter, you will have 30 days to return this form to us for further review. Should you have any questions concerning this request, please contact a personal health assistant at 1-844-234-4472.

We thank you for your assistance regarding this matter.

Sincerely,

Your Dedicated MotivHealth Insurance Team

# Accident Form

motivhealth®

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Sandy, UT 84070-9718
Customer Service: 1-844-234-4472

| Member Name: | Claim #: | Member ID #: |
|---|---|---|

**Was the treatment in question a result of one of the following?** **Date of Injury:** _____

☐ Motor vehicle accident ☐ Injured at patient's home ☐ Injured on someone else's property
☐ Injured at work ☐ Other

**Please briefly describe what happened or led to the accident or injury:** _____

_____

_____

| | |
|---|---|
| **Motor Vehicle Accident** (Auto, Motorcycle, Boat, or ATV) | **Patient was:** ☐ **Driver** ☐ **Passenger** ☐ **Pedestrian** ☐ **Motorcyclist**<br>State in which accident/injury occurred: _____<br>List all family members involved: _____<br>Auto Insurance Carrier: _____ Claim/Policy: _____<br>Adjuster's Name: _____ Phone: _____<br>Other Party's Insurance Carrier: _____ Claim/Policy: _____<br>Adjuster's Name: _____ Phone: _____ |
| **Work-Related Injury** | Employer's Name: _____ Phone: _____<br>Work comp Insurance Carrier: _____ Phone: _____<br>Adjuster's Name: _____ Phone: _____ |
| **Injury Occurred on Someone Else's Property** | Name of Other Party: _____<br>Other Party's Street Address: _____<br>City: _____ State: _____ ZIP: _____<br>Their Insurance Carrier: _____ Claim #: _____<br>Adjuster's Name: _____ Phone: _____ |
| **Attorney Information** | **Are you pursuing a personal injury claim?** ☐ **Yes** ☐ **No**<br>Attorney Name: _____ Phone: _____<br>Law Firm Name:: _____<br>**Has the claim been settled?:** ☐ **Yes** ☐ **No** **Date Settled:** _____<br>With whom did you settle: _____ |

**The above information is true and correct to the best of my knowledge.**

Member Signature: _____ Date: _____

Please mail form to: PO BOX 709718 Sandy, UT 84070 or Fax to: 844-533-1289.