INTEGRIS HEALTH

Accident Letter

Patient Name: _____ Account # _____

Date of Service: _____

To Whom It May Concern:

Our records show your hospitalization could have been the result of an accident. We need to obtain your liability information. The liability carrier may be primary to your health insurance. Please complete the following questions:

1. What type of accident occurred?

☐ Motor Vehicle Accident ☐ Fall ☐ Other _____

2. Date of Accident _____ Accident Location (Be as specific as possible) _____

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3. Was there another party involved? ☐ Yes ☐ No

If yes, Name _____

Address _____

City _____ State _____ Zip _____

Phone number _____

4. If the accident was fault of your own, list

Attorney name or Insurance agent: _____

Attorney or Insurance agent Phone # _____

Insurance Company _____

Insured Name _____ Policy number _____

5. If the accident was the fault of another party, please list the responsible party's insurance information.

Attorney name or Insurance agent _____

Attorney or Insurance agent Phone # _____

Insurance Company _____

Insured Name _____ Policy number _____

If an accident report is available, please attach a copy to this form and specify which agency filled out the report. Return in the envelope provided. If you have any questions, please contact the Business Office at 405-252-8400.

Patient Label

Patient Name:

MRN:

DOB: