Injured Party Information

Full Name:

Date of Birth:

If there are any additional involved plan members, please add them in the comments section.

Injury/Incident Details

Date of Initial Accident or Injury:

Description of Accident:

Type of Injuries Sustained:

Health Insurance Information

Health Plan Provider: (e.g., Cigna, Aetna)

Health Insurance ID Number:

Name of Employer or Company Funding the Health Insurance Plan:

Please email or fax any health insurance cards.

Claim Contact Information

Law Firm's Name:

Insurance Company Name:

Attorney's Name:

Insurance Company Name:

Paralegal or Case Manager's Name:

Claim Number:

Coverage Type:

Claim Handler or Adjuster's Name:

Phone Number:

Email:

Fax Number:

Has this Case Settled?

- [ ] Yes
- [ ] No

Additional Contact for Potential Follow-Up

Email:

Additional Comments or Plan Members Involved: