Accident Claim Form

Allegiance℠ by Cigna Healthcare

Failure to answer all questions or return all pages of this form may result in claims not being processed.

This form can also be completed online at www.askallegiance.com/Submissions/Health/AccidentInjury

Date	Claim #	Name of Treating Physician
Date of Service	Injured Person	Name of Employer/Plan Sponsor
Policyholder		Participant ID#

Dear _____ ,

We have received the above claim indicating a possible accident or injury. Please complete the following questionnaire and return it to: **PO Box 3018, Missoula, MT 59806-3018. If you have any questions, please call 1-800-877-1122. Our fax number is 1-406-523-3111**.

Accident/Injury Questionnaire

Was the above date-of-service the result of an accident/injury? ☐ Yes ☐ No

If no, please explain:

If yes, please list the date of the accident/injury:

Please describe **how** the accident/injury occurred:

Please describe **where** the accident/injury occurred:

If accident/injury took place on a premises other than your property, is there homeowner or premises insurance available? ☐ Yes ☐ No

If yes, please provide details:

Please describe what body parts were involved in the accident/injury:

Did the accident/injury happen while you were working? ☐ Yes ☐ No

If yes, has the employer been notified? ☐ Yes ☐ No

If yes, please list the date the employer was notified:

If the accident/injury happened while you were working, please describe the circumstances of the accident/injury:

Was the accident/injury the result of a motor vehicle accident? ☐ Yes ☐ No

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Group #	Participant ID #	Patient Name

Accident/Injury Questionnaire *(continued)*

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Driver's Name:

Policyholder's name (if not the same as driver):

Auto Insurance Company: Phone:

Claim Number:

Was a traffic citation issued? ☐ Yes ☐ No

If yes, to whom?

Is there medical coverage available through the automobile insurance policy? ☐ Yes ☐ No

If yes, how much? $ Number of vehicles involved:

Is there other insurance coverage (other than listed above) available for the accident/injury? ☐ Yes ☐ No

If yes, please provide the following information:

Name of Other Insurance Company: Phone Number (*with area code):*

Address: City, State, Zip:

Is another party liable for the accident/injury? ☐ Yes ☐ No

If yes, please provide the following information:

Name: Phone Number *(with area code) :*

Address: City, State, Zip:

Do you intend to retain an attorney? ☐ Yes ☐ No

If yes, please provide the following information:

Name: Phone Number *(with area code):*

Address: City, State, Zip:

Is there anything else you would like us to know about this accident/injury? Please explain:

Your Phone Number: Alternate Phone Number:

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

Signature of injured person
(If injured person is younger than 18 years old, then a guardian must sign.)

Date *(mm/dd/yyyy)*

Printed name of person signing above