ACCIDENT REIMBURSEMENT ARRANGEMENT

Attach your doctor or hospital bill to this form and complete the following steps:

1. Complete the **Patient and Employee** section below.
2. Please complete **ALL SECTIONS BELOW.**
3. The doctor or hospital bill ***must*** show the following for ***each*** service:
   - **a)** An **accident CPT or procedure** code or description of the service provided,
   - **b)** The date of service, and
   - **c)** The charge for the service.
4. To file claims for more than one patient, even if the charges are on one billing, you ***must***:
   - **a)** Complete a separate form for each patient, and
   - **b)** Attach a separate copy of the doctor's billing to each patient's form.
5. Mail all forms to: **P5 Health Plan Solutions; PO Box 9554; Salt Lake City, UT 84109-0554. Claims questions: 800-922-1855.**

PATIENT & EMPLOYEE INFORMATION

Patient's Name (First Name, Middle Initial, Last Name)	Patient's Date of Birth	Employee's Name (First Name, Middle Initial, Last Name)

Patient's Gender	PATIENT'S RELATIONSHIP TO EMPLOYEE	Employee's Social Security Number
[ ] Male [ ] Female	Self [ ] Spouse [ ] Child [ ] Other [ ]	

Do you or any of your dependents have other medical or dental coverage? (This includes Medicare)	**Employer's Plan Number:**
[ ] Yes [ ] No	**5837 Employers Resource Benefit Trust**

Coverage is for (check all applicable boxes):	Employee's Address (Street, City, State, Zip Code):
[ ] Employee [ ] Spouse [ ] Child	

Name and Address of Other Carrier	ID Number with Other Carrier
	Group Number/Name with Other Carrier

Has the other carrier paid on this claim? [ ] Yes [ ] No If yes, attach a copy of the Explanation of Benefits

If claim is on a patient 19 or over, is patient a full-time student, supported by you and unmarried?
If YES, Name of School:

[ ] Yes [ ] No

ACCIDENTAL INJURY INFORMATION (Please Complete This Section Below and Attached Statement of Claim Form)

Date of Injury.	Describe how and where the injury occurred.

To your knowledge, who was responsible for the accident?

Have you received settlement from the responsible party?	[ ] Yes [ ] No	Has the patient filed a claim with the Industrial Accident Commission?	[ ] Yes [ ] No
Do you intend to make a claim against the responsible party?	[ ] Yes [ ] No	Has the patient notified his or her employer of this condition?	[ ] Yes [ ] No
Was the condition the result of an automobile accident?	[ ] Yes [ ] No	Is the patient covered by a liability coverage other than Worker's Compensation for work related injuries?	[ ] Yes [ ] No
Was this injury or illness sustained while performing work required by the patient's employer?	[ ] Yes [ ] No	Has the patient filed a claim with his or her employer's liability coverage?	[ ] Yes [ ] No
Is the patient covered by Workers' Compensation?	[ ] Yes [ ] No		
Is the patient self-employed?	[ ] Yes [ ] No		

I,_____, authorize payment of medical benefits to the physician or supplier of services described and verify that such payment is not being reimbursed by Workers' Compensation.

X _____
Signed Date

PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any insurance company, prepayment organization, employer hospital, or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Signed Date