Interactive Medical Systems

Accident Information

Employee Name: Phone number:

Address:

Employer Group Name or Number:

Patient Name:

Date of Birth:

We are in need of additional information from you for accurate and timely claims processing. Please complete the following information, sign and return to Interactive Medical Systems. As stated within the Summary Plan Document you will have 30 days from the date of this letter to submit required information:

Date of Accident:

How Accident Occurred:

Where Accident Occurred:

If charges are not a result of an accident or injury, please indicate here and provide a brief explanation:

Employee/Patient Signature: Date:

Thank you for your prompt attention to this matter. Please contact 1-800-426-8739 x 5050 with any questions.

Sincerely,
Interactive Medical Systems Claims Department