Allina Health

WORKERS' COMPENSATION (W/C) / MOTOR VEHICLE ACCIDENT (MVA) CLAIM INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Address: _____
Street *City* *State* *Zip*

- This form must be filled out completely in order for us to process your claim through a Workers' Compensation or Motor Vehicle Insurance Company.
- You will need to get this information from your employer, work comp adjuster or insurance agent. We will need to have all information indicated below before your visit will be billed to insurance.
- **Until you are able to obtain all of the following information, you will be billed for these charges.**

Claim Number: _____ Date of Injury/Accident: _____

Body Part(s) involved: _____ What side of body injured? ☐RIGHT or ☐LEFT

Has your claim been Denied (W/C) or Benefits Exhausted (MVA)? ☐YES or ☐ NO

Do you have an Attorney? ☐YES or ☐ NO Name: _____ Phone# _____

Do you have a W/C QRC? ☐YES or ☐ NO Name: _____ Phone# _____

For Worker's Compensation (W/C)

Employer at Time of Injury: _____ Employer Phone: _____

Employer Fax: _____ Has 1st Report of Injury been filed? ☐YES ☐NO

Employer Address: _____
Street *City* *State* *Zip*

W/C Adjuster Name: _____ W/C Adjuster Phone # _____

W/C Insurance Name: _____ W/C Adjuster Fax# _____

W/C Billing Address: _____
Street *City* *State* *Zip*

For Motor Vehicle Accident (MVA) In what State did the MVA occur? _____

Name of Insurance Policy Holder: _____ Policy Holder Date of Birth: _____

MVA Insurance Contact name: _____ MVA Phone# _____

MVA Insurance Company name: _____ MVA Fax # _____

MVA Billing Address: _____
Street *City* *State* *Zip*

- Provide us this info by calling 612-262-9000 or fax the completed form to 612-262-4077 Attn: Customer Service.
- You can also email this information to us at Contact.Center@Allina.com
- Thank you for your cooperation, **Allina Health**