# ACCIDENTAL INJURY FORM

MEMBER NAME:

MEMBER NUMBER: GROUP NUMBER:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

RE: PATIENT NAME: ______________________________ CLAIM NO: ______________

We have received a claim for the patient mentioned above. The claim appears to be the result of an accident or an injury. We are unable to process your claim until the following information is received:

1. Are the services mentioned below due to an accident or injury? Yes ☐ No ☐
   *(If you answered "No" to question 1, skip questions 2-4)*
2. When did the accident or injury occur? ______________________________
3. Where did the accident or injury occur? ______________________________
4. How did the accident or injury occur? ______________________________

   ______________________________
5. The accident or injury is related to:
   - ☐ My place of employment
   - ☐ A motor vehicle
   - ☐ None of the above
6. Have you or do you intend to file a liability claim or lawsuit? Yes ☐ No ☐

I certify that the above information is true and correct.

Signature Date:

BlueLink TPA • **PO BOX 64668 • St. Paul, Minnesota 55164-0668**

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