DGA-PRODUCER PENSION & HEALTH

ACCIDENT INFORMATION FORM

Participant:
Health Plan ID:
Claim Number:
Patient Name:
Provider Name:

Was this claim related to an accident/injury? ☐ Yes ☐ No

If no, indicate here and sign at the bottom.

ACCIDENT DETAILS

Please provide the following information about the accident or injury related to the claim above.

Date of accident/injury: _____

Location: _____

Description:

Was the accident/injury work-related? ◯ Yes ◯ No

Did the injury occur as a result of an auto accident? ◯ Yes ◯ No

Was a third party involved? ◯ Yes ◯ No

If a third party was involved, is a lawsuit possible? ◯ Yes ◯ No

Reimbursement from any other third party insurance? ◯ Yes ◯ No

Please return this form to us within 30 days of receiving this letter to the address or fax number below:

DGA–PRODUCER HEALTH PLAN
5055 WILSHIRE BLVD STE 600
LOS ANGELES, CA 90036
Fax: (323) 782-9287

X _____ _____

Participant's Signature Date