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Diplomate American Board of
Orthopaedic Surgery
Board Certified
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Board Certified

Kessler Sports Medicine Center

Arthroscopy Shoulder
Knee and Elbow Surgery
Orthopaedic Surgery

Incident Report

Dear Member,

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. In order to expedite your claim(s) process, please complete the following information.

Note: If the reason for your medical care was not due to an accident related injury, do not complete Section I of the questionnaire. You should complete Section I and III only when applicable.

Patient Name: _____
Provider Name: _____ Date of Service: _____

SECTION I

Is the reason for your visit to your doctor due to an injury caused by an accident?
Yes_____ No_____
If so, please indicate:
Auto_____ Home_____ School_____ Other_____
Date of Accident _____ How and where accident happened: _____

Was a third party responsible for the injury? Yes_____ No_____
Is so, provide the following:
Name of individual or company: _____
Name and address of attorney representing third party insurance company or party responsible:
_____
_____

SECTION II

Full name of your spouse: _____
Spouse's Birth Date: _____ Social Security Number:_____
Spouse's Employer: _____
Employer's Address: _____
_____Telephone Number: _____
Is your spouse covered by any other Health Insurance Company: _____Yes_____ No
If YES, give name, address and telephone number of Health Insurance Company:
_____
_____Telephone Number: _____
Policy Number: _____Effective Date: _____
Type of Coverage: Family _____ Couple _____ Single _____
Do you have Medicare coverage?
Part A_____ Effective Date:_____ Part B _____ Effective Date: _____

Section III (Information to be filled out only if auto accident)

Were you in your own or someone else's vehicle? _____
Name of your auto insurance company _____
Amount of PIP coverage:_____ Amount of Deductible: _____
If represented by an attorney, please provide the following: Attorney name, address and telephone number:
_____
_____

Subscriber/Member Signature _____ Date_____

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