



Phone (706) 841-7000 • Toll Free (877) 937-9602  
Fax: (706) 841-7020 • www.nifmcp.com

## ACCIDENT FORM

Return the completed form by fax to (706) 841-7020, by email to [fmcp\\_customer\\_service@nifmcp.com](mailto:fmcp_customer_service@nifmcp.com) or by mail to:  
NECA/IBEW Family Medical Care Plan  
410 Chickamauga Avenue, Suite 301  
Rossville, GA 30741

We have received a claim for treatment that may be the result of an accident or injury. Please complete this form regarding the claim in question. Be sure to correct any mistakes to the information provided, and be as specific as possible in answering the questions below. Failure to provide the information requested may cause your benefits to be suspended in accordance with your Plan's Summary Plan Description. We must receive this completed form to continue processing this claim. You may use additional pages if necessary.

Member Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Potential Accident Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Service Date: \_\_\_\_\_

Please provide a phone number we can use to contact you: \_\_\_\_\_

Was the condition being treated the result of an accident or injury?  Yes  No

If No, please briefly explain why medical service was sought: \_\_\_\_\_

On what date did the accident or injury occur? \_\_\_\_\_

Is this condition a result of injury sustained during the course of employment?  Yes  No

How did the accident or injury occur?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where did the accident or injury occur?

\_\_\_\_\_  
\_\_\_\_\_

Do you feel that another party is responsible for this accident or injury?  Yes  No

If Yes, please provide a brief description of that party's involvement in the accident or injury. You may use additional pages if necessary. Attach a police report if applicable.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If Yes, please provide their name and contact information:

\_\_\_\_\_

Are you pursuing reimbursement from another party or insurance carrier in relation to this injury?  Yes  No

If known, please provide information on the responsible party's insurance carriers, including any claim numbers:

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Have you hired an attorney?  Yes  No

If Yes, please provide your attorney's name, address, and phone number:

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Has a lawsuit been filed?  Yes  No

If Yes, state the court in which it was filed, the date of filing, and the court number:

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If No, do you plan to file suit?  Yes  No

If No, explain why you will not pursue a claim or suit:

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Please provide the carrier name, address, and policy number for all other insurance coverage you have.

Home:

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Auto:

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Other:

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Member Signature \_\_\_\_\_ Date \_\_\_\_\_