



DATE

EMPLOYEE:

SS#

PATIENT:

DATE OF SERVICE:

TO:

GROUP NAME:

We have recently declined a claim on you/your family member for additional information. Please complete this questionnaire and return to us.

1. Date of Accident/Injury: \_\_\_\_\_
2. Description of the Accident/Injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Location of the Accident/Injury: \_\_\_\_\_
4. Was this incident work related?                      Yes                      No

Upon receipt of this completed questionnaire we will reconsider your claim for payment. Our phone number is 888-419-1094.

**PLEASE SUBMIT ACCIDENT DETAILS**

In addition, would you please affix your signature to the bottom of this letter and date it, indicating that the information contained is accurate to the best of your knowledge. Your cooperation is, of course, appreciated!

**BY SIGNATURE AFFIXED AND DATED HEREWITH, I STATE THAT THE FACTS STATED ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date Signed

Sincerely

TRIBAL HEALTH PARTNERS  
PO Box 71490  
Phoenix, AZ 85050