THIRD PARTY LIABILITY / ACCIDENT / INJURY INFORMATION FORM

Member Details

Member Name (first, middle, last name):

Address (Street Address, City, State, Zip Code):

Telephone (with area code):

Date of Birth:

Member ID #:

Social Security Number:

Email:

Dependent Information (Fill out the information below if this claim is on a dependent)

Dependent Name:

Relationship to Member:

Address:

Date of Birth:

Telephone:

NOTE: If this claim is on a dependent who is 18 years of age or older, the dependent must submit a HIPAA PHI Release Form available at advantagehealthplans.com. The Kempton Company may not speak with the member regarding claim details without this form.

Accident / Injury Details

Is this claim the result of an accident? ☐ Y ☐ N

Was this claim related to the patient's employment? ☐ Y ☐ N

Was this claim related to a motor vehicle accident? ☐ Y ☐ N

If you answered "yes" to any of the above, please fill out the information below:

Date of accident or injury:

Location of accident:

Detailed description of how accident or injury occurred *(please attached additional sheet if necessary)*:

Instructions:

Please return this form to Advantage Health Plans Trust via email to customerservice@kemptongroup.com or via fax to (405) 608-5831.

Signature

The information provided is truthful and accurate to the best of my knowledge. I understand that if claims were incurred due to third party liability or performing work for which I have been compensated, the Plan has the right to recover any payments made by the Plan. I understand that if claims were incurred due to third party liability or performing work for which I have been compensated, the Plan has the right to recover any payments made by the Plan. Please see your Summary Plan Description for more information.

Member Printed Name:

Signature of ***Member:*** Date:

Signature of ***Patient:*** Date:
(Only if patient is age 18 or over)