Accident
Information Form

HealthPartners

We have received your claim and the details provided indicate the treatment may have been the result of an accident or injury. Before your benefit entitlement can be assessed, please complete the information below. Once you have completed the form, please return it to **Health Partners Claims Assessor, Reply Paid 1493, Adelaide SA 5001** or **email ask@healthpartners.com.au**

Section A – Patient details

Member number

Name *(first name)* *(surname)*

Date of birth *(dd/mm/yyyy)*

Section B – Accident Details

1. Particulars of accident

Was the injury the result of an accident?

☐ Yes *(please complete questions 2 to 7)* ☐ No *(please complete questions 2a and 2b)*

2. Details of the accident/injury/condition

a. Date and time of the onset of the accident/injury/condition

Date Time : (am/pm)

b. Describe how the accident/injury/condition occurred

c. Place of accident/injury

d. Describe the nature of the injury sustained and when the symptoms first appeared

e. Names and addresses of any witnesses

f. Did you seek medical attention?

☐ Yes *(please complete questions g)* ☐ No *(go to question 3)*

Date consulted Time : (am/pm)

Please provide details of treating practitioner:

Name

Address

Phone number

g. Please attach a copy of the doctor/hospital/police report or claim form which was completed at the time of your accident/injury *(if available)*.

3. Are you entitled to claim:

a. Workers compensation

☐ Yes *(go to question 4)* ☐ No* *(Claim refused? Yes^/No)*

b. Third party damages from persons liable?

☐ Yes *(go to question 5)* ☐ No *(Claim refused? Yes^/No)*

c. Damages for persons liable at law, e.g. Public Risk?

☐ Yes *(go to question 6)* ☐ No*

*If you answered 'No" to all the questions above, go to Section C to complete your declaration. ^If you have claimed under Workers Compensation or Third Party and have been refused, please attach a certified copy of the official letter of refusal with written confirmation that no appeal will be lodged.

4. Workers' Compensation *(to be completed if work-related)*

a. Did the accident/injury happen at work?

☐ Yes - *provide name and address of employer* ☐ No

Work cover claim number

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Health Partners

Section B – Accident Details *(cont.)*

b. Do you intend to claim Workers' Compensation?

☐ Yes ☐ No – *give reasons (e.g. self-employed)*

Insurer details and address

5. Third Party Insurance *(to be completed if a motor accident)*

a. Name the driver of your vehicle *(if applicable)*

b. Name the owner of your vehicle *(if applicable)*

c. Was another vehicle involved?

☐ Yes ☐ No

d. Name and address of the negligent party

e. Do you intend to claim against the Third Party?

☐ Yes ☐ No – *give reasons*

TAC/CTP claim number

Insurer details and address

6. Damages/Compensation *(e.g. public liability)*

a. Do you intend to claim damages from any other party?

☐ Yes ☐ No – give reasons

7. Are you being represented by a lawyer or any other party in relation to your accident/injury/condition?

☐ Yes - *give details* ☐ No

Surname

First name

Address

Postcode

Phone number (including area code)

Email address

Section C – Member Declaration *(please tick)*

☐ I authorise Health Partners to contact any hospital, medical or other providers to supply any information required to assist Health Partners in assessing my claim.

☐ Should Health Partners hold any entitlement to reimbursement of incorrectly paid benefits, I authorise Health Partners to release relevant claims history information to my lawyer, insurer or appropriate authority to facilitate reimbursement of health insurance benefits paid on my behalf by Health Partners.

☐ I hereby declare that the information provided on this form is true and complete.

Signature Date