Member: _____

Member ID: _____ Group No.: _____

Claimant/Patient: _____ Claim No.: _____

We have received information indicating the above claimant may have been involved in an incident or accident. In order for us to properly process the charges related to this injury, this form must be fully completed and submitted to us as soon as possible.

Date of Accident or Injury: _____ Claimant Phone No.: _____

Accident or Injury Related to: Work ☐Yes ☐No - Motor Vehicle ☐Yes ☐No – Other ☐Yes ☐No

(If Motor Vehicle, **attach** copy of police report and copy of your Auto Insurance card)

Description of Accident / Injury and location: _____

_____

_____

_____

LIEN AND ORDER DIRECTING REIMBURSEMENT OF MEDICAL PAYMENTS

I hereby authorize and direct reimbursement directly to Affordable Benefit Administrators, Inc., amounts otherwise payable, but not to exceed the medical benefits paid on my behalf for medical and/or dental expenses incurred as a result of the accident in which I was involved.

I agree to take all reasonable steps and execute all documents that are necessary to assure prompt reimbursement to Affordable Benefit Administrators, Inc. for settlement with any and all third parties.

I further authorize Affordable Benefit Administrators, Inc. to obtain and disclose information deemed necessary for the proper evaluation and benefit determination.

The following information is required (if not applicable, please indicate N/A).

Third Party / Person / Entity Information:

Name: _____ Telephone No: _____

Name, Address & Telephone number of third party's Insurance Company:

Name: _____ Telephone No: _____

Address: _____

Policy No./Case No.: _____

Name, Address & Telephone No. of your attorney:

Name: _____ Telephone No: _____

Address: _____

Signature (required): _____ Date: _____

Affordable Benefit Administrators, Inc.
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Phone (800) 350-0148 Fax (818) 842-0225