MISSOULA COUNTY

Missoula County Employee Benefits Plan
200 W. Broadway
Missoula MT 59802-4292
(406) 523-4876 Fax (406) 523-4731

Accident/Injury Information Request

Please complete in full and sign.

1. General information

Employee/insured: _____ **Social Security/ID #** _____

Employee address: _____

Employee agency/department: _____ **Contact #** _____

Name of injured person: _____ **Relationship to employee:** _____

2. Reason for seeking medical attention

Is this condition due to an accident, i.e. cut, fracture, sprain or strain? YES ☐ NO ☐ If you marked NO, you may skip to the bottom of this page and sign. If you marked YES, then provide the following information.

AUTOMOBILE ☐ HOME ☐ OTHER ☐

Briefly describe how and where accident/injury happened. _____

_____

_____

Date of the accident/injury occurred: _____ **Date first treated:** _____

Name of physician first consulted: _____

***WORK-RELATED ☐**

***If you marked the WORK-RELATED box, you must file the claim with Workers' Compensation.**

3. Third party liability information

Please provide the following information if someone else is liable for this injury, i.e. car insurance, homeowner's insurance.

Name of company: _____

Name of policyholder: _____

Policy # _____ **Phone #** _____

I certify that the foregoing statements, including accompanying statements, are true and complete to the best of my knowledge. I authorize any physician, hospital, insurance company, organization or employer to release any information, including full copies of their records to Missoula County Risk and Benefits for any medical services, treatments or benefits rendered or payable to me (or my dependents). A photocopy of this authorization shall be as valid as the original.

Employee signature _____ **Date** _____

Patient signature (if 18 years or older) _____ **Date** _____