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 name: _____ ID # _____

Employee address: _____

Employee 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 ☐

Briefly describe how and where accident/injury happened: _____

_____

_____

Body part injured: _____ Date of the accident/injury occurred: _____

Date first treated: _____ Name of physician first consulted: _____

***Is this injury WORK-RELATED YES ☐ NO ☐**

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

Where did the accident/injury occur:

AUTOMOBILE ☐ HOME ☐ OTHER ☐ Describe: _____

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** _____