Allina Health

WORKERS' COMPENSATION (W/C) / MOTOR VEHICLE ACCIDENT (MVA) / THIRD PARTY LIABILITY (TPL) INFORMATION

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Address: _____
Street *City* *State* *Zip*

- The applicable section(s) of this form must be filled out completely in order for us to process your claim through a Workers' Compensation Motor Vehicle or Third Party Liability Insurance Company.
- You will need to get this information from your employer, work comp adjuster or insurance agent. We will need to have all information indicated below before your visit can be billed to insurance.
- **If we do not receive this form back within 20 days, you may be billed for these charges.**

Claim Number: _____ Date of Injury/Accident: _____

Body Part(s) involved: _____ What side of body injured? ☐RIGHT or ☐LEFT

Place of injury: ☐Home ☐Work ☐Other Address of injury location: _____

Has your claim been Denied (W/C) or Benefits Exhausted (MVA)? ☐YES or ☐ NO

Do you have an Attorney? ☐YES or ☐ NO Name: _____ Phone #: _____

Do you have a W/C QRC? ☐YES or ☐ NO Name: _____ Phone #: _____

For Worker's Compensation (W/C)

- If you do not know the name of your employer's workers' compensation insurer or the claim number, ask your employer, or call the Department of Labor and Industry at 800-342-5354 (toll-free), or 651-284-5032.

Employer at Time of Injury: _____ Employer Phone: _____

Employer Fax: _____ Has 1st Report of Injury been filed? ☐YES ☐NO

Employer Address: _____
Street *City* *State* *Zip*

W/C Adjuster Name: _____ W/C Adjuster Phone # _____

W/C Insurance Name: _____ W/C Adjuster Fax# _____

W/C Billing Address: _____
Street *City* *State* *Zip*

For Motor Vehicle Accident (MVA) / Third Party Liability (TPL)

State Accident Occurred: _____

Name of Insurance Policy Holder: _____ Policy Holder Date of Birth: _____

MVA/TPL Insurance Contact name: _____ MVA/TPL Phone# _____

MVA/TPL Insurance Co. name: _____ MVA/TPL Fax # _____

MVA/TPL Billing Address: _____
Street *City* *State* *Zip*

- Provide us this info by calling 612-262-9000 or fax the completed form to 612-262-4077 Attn: Customer Service.
- You can also mail it to us: Allina Health, Attn: Customer Service, PO Box 43 MR 10209, Minneapolis, MN 55440
- You can also email it to us at SubmitDocument@allina.com

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