RMH RANSOM MEMORIAL HEALTH

ACCIDENT AND INJURY REPORT

Ransom Memorial Health Physician Practices and RMH Express Care

PRIVATE/PUBLIC PROPERTY	**Patient Name:** **DOB:**
	Date of Injury: **Where did accident occur?** **State of Occurrence:**
	Briefly describe events of accident or how injury occurred:
	Property Owners Insurance Information (if applicable), Claim # and Billing Address:
AUTO	**Patient Name:** **DOB:**
	Date of Injury: **Where did accident occur?** **State of Occurrence:**
	Briefly describe events of accident or how injury occurred:
	Auto Insurance Claim #, Billing Address and Phone number:
WORK COMP	**Patient Name:** **DOB:**
	Date of Injury: **Where did accident occur?**
For Office Use:	**Briefly describe events of accident or how injury occurred:**
Verified by:	**Did you notify Employer:** ❑ **YES** ❑ **NO** **Is today's care authorized?** ❑ **YES** ❑ **NO**
	Employer Full Name
Originating Office:	**Employer Contact/Supervisor Name and Phone #**
	Employer Address:
Date:	**Work Comp Insurance Carrier Info:**
	Work Comp Claim# **Case Manager's Name** **Phone #** **Fax #** **Additional Info:**

In the event the insurance I provide denies payment or does not pay in full, I understand I am responsible for the remaining balance as explained in the Ransom Memorial Health Physician Practices/RMH Express Care Financial Policy.

PATIENT SIGNATURE_____**Date:**_____