UNITE HERE HEALTH
ALASKA

Accident Inquiry

You may have gotten an Accident Inquiry form in the mail. Please fill this form out or the one you got in the mail.

Participant ID: ______________________ Patient Claim Number: ______________________

Participant Name: ______________________ Account Number: ______________________

Before this claim can be processed, we need answers to all of the following questions. Please fill out this questionnaire completely and mail it to:

Culinary Health Fund C/O NexClaim Recoveries
75 Farmington Valley Drive
Plainville, CT 06062

It's ok if you do not know the information in this box. You can skip it and complete the rest of the form.

The claim is for:

Provider: ______________________ Date of Service: ______________________

Service: ______________________ Dollar Amount: ______________________

1. When did the illness or injury occur? Date (MM/DD/YY): ______________________
2. Where did the illness or injury occur? ______________________
3. How did the illness or injury occur? ______________________
4. Is this illness or injury someone else's fault? ( ) Yes ( ) No

   Explain: ______________________
5. Is your illness/injury related to your job duties at work? ( ) Yes ( ) No
   (Explain below and if yes, continue to 6 and 7)

   Explain: ______________________
6. Did you report the condition to your employer? ( ) Yes ( ) No
7. Do you expect to receive or have you been provided with Workers' Compensation Benefits? ( ) Yes ( ) No
   Note: Workers' Compensation is not the same as state disability.

Patient Signature: ______________________ Date: ______________________

If you have any questions, please contact our Customer Service Office at 888-468-4742

Note: We will not send another request for this information. If information is not received within 45 days of receipt of this letter, this claim will be denied, and you will be billed by your provider. If the information is received within 45 days, the claim will be processed within 15 days of receipt.