EXPLANATION OF ACCIDENT/INJURY

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-328-8623 • Website: www.aseahealth.org

Use this form, as directed by the ASEA Health Trust Administrator, to describe the details relating to an accident or injury for which benefit claims have been submitted.

PLEASE PRINT CLEARLY

Date:

Employee name: SSN or Alternate ID:

Services provided by:

Patient name: Date of service:

Claim number:

Date occurred: Time: ❑ AM ❑ PM

Please describe in detail how and where the incident occurred:

Is this a work-related accident? ❑ Yes ❑ No

Was a third party involved (for example, was another person or party, whom you may be considering making a claim against, responsible for the patient's injuries)? ❑ Yes ❑ No

CERTIFICATION

I certify that the above is true, correct and complete.

Employee signature: Not required if submitted on-line Date:

Any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties.

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