Pequot Plus Health Benefit Services
Benefit Administrators
P.O. Box 3620
Mashantucket, CT 06338-3620

Questions? Please contact Customer Service at (860) 396-6489 or (888) 779-6872

Date: _______________

Employee _______________________
Patient _________________________
ID #: ___________________________
Claim #: _______________________
****ACCIDENT/INJURY UPDATE REQUIRED****

Cell Phone: _________________
Home Phone: ________________
Email: _____________________

Please provide us with the information requested below to complete the processing of the claim(s) for the above-mentioned patient. In accordance with the terms of your health plan, we must have this information within **forty five (45) days** of the date indicated above.*

What was the date of the injury? ____
What types of injuries were sustained? ____
Please describe where and how the injury happened: _____________________________
____
Was a police report filed? ______ Yes ______ No
If yes, please provide a copy of police report.

If injuries occurred as the result of a motor vehicle accident, please also complete Section A. If injuries occurred while at work, please also complete Section B.

SECTION A-MOTOR VEHICLE ACCIDENT INFORMATION

Were you the ____ Driver or ______Passenger?
If you were the driver, please include a copy of the police report.
Is there medical coverage through your auto carrier? ______ Yes ______ No
Is there a law suit intended? ______ Yes ______ No

SECTION B-WORKERS COMPENSATION INFORMATION

Did you notify your employer of your injury? ______Yes ______ No
Did you file a worker's comp claim? ______ Yes ______ No
If yes, was the claim approved? ______ Yes ______ No
If no, are you still pursuing a claim? ______ Yes ______ No

Signature: __________________________________ Date: ______________________

***Please be advised that payment of these claims will not be released until the requested information is received. Further, failure to provide this information will result in the denial of your claims rendering you responsible for payment of these charges.**

Please complete, sign where indicated and mail your reply to the address listed above or fax to (860) 396-6157. If you have any questions, please call our Customer Service number listed above. Please notify this department of any future changes in your coverage. Thank you for your cooperation.

PEQUOT PLUS HEALTH BENEFIT SERVICES

FOR OFFICE USE ONLY:
Date: ____________________
Time: ____________________
CSR: ____________________