UnitedHealthcare®
Oxford

Accidental Injury Form

Please complete and mail this form with all supporting documentation to:
Oxford Coordination of Benefits Department, P.O. Box 29143, Hot Springs, AR 71903 ▪ 1-800-767-3840

Oxford ID number: _____

Was your medical treatment the result of an: Automobile accident: Yes _____ No _____ If yes, complete Section A
Work related accident: Yes _____ No _____ If yes, complete Section B
Other: Yes _____ No _____ If yes, complete Section C

A. Automobile Accident

Date of accident _____ Injuries sustained _____
Were there any other family members involved who are enrolled with Oxford? Yes____ No_____ If yes, member's name:
▪ Name _____ Injuries sustained _____
▪ Name _____ Injuries sustained _____
Was this a motorcycle accident? Yes _____ No _____
Has a motor vehicle claim been filed with your automobile carrier? Yes _____ No _____
Auto carrier information, if more than one carrier is responsible include that information:
Auto carrier name & address _____
Auto carrier phone # _____ Policy # _____ Claim # _____
Other auto carrier name & address _____
Auto carrier phone # _____ Policy # _____ Claim # _____
Have you filed a report of the injury? Yes _____ No _____ If no, why? _____
If you live in New Jersey, who have you opted to pay primary for medical claims? Check one:
Health insurance carrier _____ Auto carrier _____
If you live in Connecticut, do you have Med Pay on your automobile policy? Yes _____ No _____

B. Work-Related Accident

Date of accident _____ Injuries sustained _____
Have you filed a report of the injury? Yes _____ No _____ If no, why?_____
If yes, name and address of workers' compensation carrier _____
_____ Policy # _____Case #_____

C. Attorney Information

Have you hired an attorney? Yes _____ No _____ If yes, attorney's name_____
Address _____ _____Phone # _____

D. Complete this section if your injury occurred on property other than your own

Name and address of property owner _____
_____
Property owner's insurance carrier _____
Phone #_____ Claim #_____
Do you intend to make a claim with the property owner's insurance carrier? Yes _____ No _____

E. Applicant Signature

I certify that the above information is true and accurate to the best of my knowledge.
Print name _____ **Signature** _____ **Date** _____
Authorization to release medical records relating to this accident or injury
Print name _____ **Signature** _____ **Date** _____