



Accident/Injury Report

As a part of claims adjudication under your medical plan, Judi Health needs additional information regarding claims that indicate you or your family member may have been injured. Please complete the following form and return to inquiries@judihealth.com.

Section 1 – Patient Information

Patient Name:	Date of Birth (MM/DD/YYYY):
Subscriber Name:	ID Number:
Home Address:	
City, State, Zip:	Daytime Phone:

Section 2 – Accident/Injury Information

Location of Accident/Injury: ☐ Home ☐ Work ☐ Other	
If other, please provide address:	
Date of Accident/Injury:	
Please provide a brief description of the injury:	
If a police report was filed, please include a copy with your response.	
Do you have another insurance policy that may cover your injuries? ☐ Yes ☐ No <i>If yes, please complete the following information:</i>	
Type of Policy: ☐ Auto Insurance ☐ Homeowner's Insurance ☐ Other:	
Name of Insurance Carrier:	
Policy ID Number:	Claim Number:
Policy period:	Policy holder name:
Are you now, or plan to be, represented by a lawyer related to this injury? ☐ Yes ☐ No <i>If yes, please complete the following information:</i>	
Lawyer's Name/Practice:	
Telephone:	Email:



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Section 3 – Attestation

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature: _____

Date: _____

Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:

Email: inquiries@judihealth.com

Fax: 833-FAX-JHLT (329-5458)

Mail: Judi Health Attn: Claims Dept. 9450 SW Gemini Dr., #87234 Beaverton, OR 97008