

Plasterers and Cabinet Makers Health Fund

3001 Metro Drive – Suite 500 | Bloomington, MN 55425 | 952.854.0795 | 800.535.6373

Dear Participant:

We have received a claim that appears to be the result of an accident or an injury. We are unable to process the claim until the following information is received:

Patient Name _____ Patient Date of Birth _____

1. Were the services provided related to an accident or an injury? Yes No
2. Date of Service _____
3. Provider's Name _____
4. When did the accident or injury occur? _____
5. Where did the accident or injury occur? _____
6. How did the accident or injury occur? _____

7. Is the accident or injury the result of an auto accident? Yes No
8. Is the accident or injury related to any employment? Yes No
9. Have you or do you intend to file a liability claim or lawsuit? Yes No
If yes, please provide the name, address and phone number of your attorney. _____

I certify that the above information is true and correct.

Signature _____ Date _____

Print Name _____ ID NO. XZ _____