

Denver Metro

P.O. Box 3559
Englewood, CO 80155-3559
10771 E. Easter Ave.
Suite 250
Centennial, CO 80112
Telephone (303) 770-5710
Fax (303) 770-2743



www.cnichs.com

Colorado Springs

740 Wooten Road, Suite 104
Colorado Springs, CO 80915
Claims Only: P.O. Box 76149
Colorado Springs, CO 80970
Telephone (719) 622-3300
Fax (719) 591-8817

Group Number: _____
Employee: _____
Patient: _____
Claim Number: _____

CNIC has received a claim for the above-mentioned claimant. In order to give proper consideration to this claim, please provide the following information.

1. Date and time of the accident/injury: _____
2. Location of the accident/injury (work, home, school, store, etc.) _____
Please include full address _____

3. Did the accident/injury occur at work? Yes _____ No _____
4. Please describe how the accident/injury occurred: _____

5. Injured person's place of employment at time of incident:

Supervisor _____ Phone _____
5. Was the incident reported to the Police Department? Yes _____ No _____
If yes, you must attach a copy of the Police Report.
6. Was the injury the result of an auto or motorcycle accident? Yes _____ No _____
If yes, please complete the following:
Was it an auto OR motorcycle accident? Auto _____ Motorcycle _____
Do you carry personal injury coverage on your auto insurance? _____
Name of your auto insurance company _____
7. Is there another party responsible for the accident/injury? Yes _____ No _____
If yes, please provide name and address. _____

8. Is there another insurance company involved in this case? Yes _____ No _____
If yes, please provide name and phone number. _____

9. Legal Action

Have you commenced legal action? Yes _____ No _____

Do you intend to take legal action? Yes _____ No _____

If you have consulted an attorney, please furnish his/her name and address:

10. Have you been contacted by an attorney or representative of an insurance company about this matter? Yes _____ No _____

If yes, please furnish name and address: _____

11. Have you received any settlement for injury? Yes _____ No _____

If yes, please provide:

Amount of Settlement: \$ _____ Date of Settlement: _____

12. Please include any other pertinent comments or information: _____

Please sign and date where indicated below. Please also provide us with your phone number so that we may contact you in the event we have more questions.

Signature of employee: _____ Date _____

Signature of claimant: _____ Date _____

Phone number: _____

Please submit the requested information or attach the requested documentation to this letter and return to the CNIC office.

Thank you for your cooperation.

CNIC Health Solutions