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

CNIC
Health Solutions®
A Rocky Mountain Health Plans TPA
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 ______________

6. Was the incident reported to the Police Department? Yes _____ No _____
   If yes, you must attach a copy of the Police Report.

7. 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 ______________________________

8. Is there another party responsible for the accident/injury? Yes _____ No _____
   If yes, please provide name and address. ______________________________
   ____

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

10. 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:
____
____

11. 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: ________________________________
____

12. Have you received any settlement for injury? Yes _____ No _____
If yes, please provide:
Amount of Settlement: $ ______________ Date of Settlement: ___________

13. 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