Altrua HealthShare

Needs Processing Form

SECTION A Head of Household Information

Head of Household's Full Name

Member ID#

Date of Birth / /

Daytime Phone ( ) –

Address

City State Zip

SECTION B Patient Information

Patients Full Name

Social Security – –

Date of Birth / /

Full Time Student/Service Volunteer Information

› Please complete if dependent is age 20 or older and attach verification

School/Charitable/Religious Organization

City State Hours

SECTION C General Information

Detailed description of symptoms and diagnosis/ treatment (If known)

Date First Noticed / /

Has the patient had symptoms before?

◯ Yes ◯ No

Is this an emergency room visit?

◯ Yes ◯ No

› If yes, you must submit this form within 96 hours of the visit.

Is this need for maternity?

◯ Yes ◯ No

Was the patient hospitalized?

◯ Yes ◯ No

Date Admitted / /

Date Discharged / /

E-mail, fax or mail this completed form.

To avoid delays, please make sure you complete and attach all required information.

SECTION D Additional Incident and Insurance Information

How did the incident happen?

Location of Incident

If you answer "yes" to the questions below, please fill in the following associated information and note any required attachments.

Is there any insurance available from other sources?

◯ Yes ◯ No

Name/Address of Insurance Company

Phone Number ( ) –

Name of Policyholder

Has a claim been filed?

◯ Yes ◯ No

Adjustor

Was this a vehicle-related incident?

◯ Yes ◯ No

› If yes, please attach a copy of police report.

Type of Vehicle

Your Auto Insurance Company

Owner of Vehicle

Owner's Auto Insurance Company

Driver of Vehicle

Driver's Auto Insurance Company

Was this a work-related incident or illness?

◯ Yes ◯ No

Employer's Name

Phone Number ( ) –

Do you have worker's compensation coverage?

◯ Yes ◯ No

Have you filed a claim?

◯ Yes ◯ No ◯ In Progress

Was this a school-related incident?

◯ Yes ◯ No

School District

Did this occur during school hours?

◯ Yes ◯ No

Did this occur as a result of an extra-curricular school sponsored activity?

◯ Yes ◯ No

Do you have or did you purchase school insurance for the activity in question?

◯ Yes ◯ No

Do you think the school may be liable for this incident?

◯ Yes ◯ No

If yes, please explain.

Is there any other insurance available that would be primarily responsible for payment of this need?

◯ Yes ◯ No

Type of Coverage

☐ Individual Policy
☐ Medicare
☐ Accident/Cancer
☐ Group/Group-Type Plan
☐ Union Health/Welfare Plan or Self-Insured Plan

Other

Coverage Information

Name of Company

Policy Number

Name of Insured

Phone Number ( ) –

Member or Representative

Signature Date / /

Do not send unless you have ***completed Sections A–D in full.***