[Date]

[Member Name]
[Address Line 1]
[City, State, Zip Code]

RE: Health Insurance Medical Claim Survey

Claim Number: [Insert Claim Number]
Date of Service: [Insert Date]
Provider Name: [Insert Provider Name]

Dear [Member Name],

We are currently reviewing a medical claim submitted for services you recently received. To ensure the claim is processed accurately and to determine if another party may be responsible for payment, we request that you complete this brief survey.

1. Was this treatment due to an accident or injury?
[ ] No (If no, please skip to the signature section)
[ ] Yes (If yes, please provide details below)

2. Type of Accident:
[ ] Motor Vehicle
[ ] Work-Related
[ ] Slip and Fall / Other

3. Briefly describe how and where the injury occurred:
_____

4. Is there another insurance company involved? (e.g., Auto, Workers' Comp)
Company Name: _____ Policy Number: _____

Please return this form within [Number] days to avoid delays in your claim processing. You may return it via mail to the address below or through our member portal.

[Insurance Company Name]
[Claims Department Address]
[Phone Number]
[Website/Email]

Sincerely,

[Staff Name/Department]
[Insurance Company Name]

Member Signature: _____ Date: _____