

[] MBA
P.O. Box 651109
Salt Lake City, Utah 84165-1109
PHONE (801) 263-3334 (800) 877-3727
FAX (801) 268-3335

**Your Claim Cannot Be
Considered Properly
Until This Information
Is Received By MBA**

DATE _____

*DATE _____

Second Request

Insured: _____

Claimant: _____

Claim#: _____

Supervisor: _____

IMPORTANT! Complete All Items As It Applies To This Claim

Insured's Employer (Company Name) _____

Insured's Name _____

Insured's Social Security Number _____

The claim we received contains the following information:

Patient Name _____

Provider of Service _____

Date of Service _____

This claim appears to have been the result of an accident. In order to maximize your benefits, we will require additional information before your claim can be processed. **Please complete and return this form with the information requested below. Your claim will be finalized when this information is received.**

1. Was this claim the result of an accident? Yes___ No___ (Please check one)

2. Date of Accident _____

3. Where did accident happen? _____

4. Please provide a brief description of how the accident occurred.

Insured Signature: _____ Date: _____

* Second Request Date. Claim will be placed in inactive file if response is not received within 10 days of this Date.