Baybridge Administrators, L.LC.
P O Box 161690
Austin, TX 78716
1-800-845-7519
Fax 1-512-275-9350

ACCIDENT CLAIM FORM
PHYSICIAN'S STATEMENT

NAME OF CLAIMANT_____ DATE OF BIRTH ____/____/____

DIAGNOSIS_____ ICD-9 CODE_____

DATE OF ACCIDENT _____/_____/_____ IS INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? _____

IF YES, PLEASE PROVIDE DETAILS _____

DATE OF FIRST VISIT____/____/____ DATE OF LAST VISIT ____/____/____ FREQUENCY OF TREATMENT_____

HAS THE PATIENT BEEN CONFINED TO A HOSPITAL FOR THIS CONDITION? _____

IF YES, PLEASE LIST NAME OF HOSPITAL AND DATES OF CONFINEMENT:

_____

HAS THIS PATIENT BEEN TREATED FOR THIS SAME OR SIMILAR CONDITION IN THE PAST, PRIOR TO THIS OCCURRENCE? _____

IF YES, PLEASE PROVIDE DIAGNOSIS, DATES OF TREATMENT AND NAME/ADDRESS OF REFERRING PHYSICIAN:

_____

_____

_____

PLEASE DESCRIBE COURSE OF TREATMENT:

_____

_____

_____

WHAT IS THE PATIENT'S PROGNOSIS?

_____

_____

WHAT IS ESTIMATED RETURN TO WORK DATE? _____

ARE THERE ANY LIMITATIONS? _____

REMARKS _____

_____

MEDICAL PROVIDER'S SIGNATURE _____ DATE SIGNED_____/_____/_____

MEDICAL PROVIDER'S NAME (PLEASE PRINT) _____

MEDICAL PROVIDER'S ADDRESS _____

PHONE NUMBER _____ FAX NUMBER_____