



ACCIDENT/INJURY/INFORMATION FORM

Member Name: _____ Date of Birth: _____

UHA ID: _____ Phone Number: _____

Is this an On the Job Injury? Yes No

If yes, Claim number: _____

Employer at time of injury: _____

Work Comp. Carrier: _____ Date of Injury: _____

Location: _____

Briefly describe how the injury occurred:

Is this a Motor Vehicle Injury? Yes No

If yes, Claim number: _____

Auto Insurance Carrier: _____

Date of Injury: _____

Briefly describe how the injury occurred:



Do you have an attorney in regards to this injury? Yes No

Attorney name: _____

Phone: _____

Questions related to accident form please phone UHA TPR Department at 541-229-7036 or 541-464-4175.

Fax: 541-677-5881

Scan and Email to: TPR@umpquahealth.com