St. Lawrence-Lewis Insurances
P.O. Box 697
Canton, NY 13617
(315)379-3000

Date:_____

Insured Name:_____
Insured Address:_____
_____

Insured SSN #_____

In order for us to properly review the claim for PATIENT_____.
Provider:_____
Date of Service:_____

Please complete the following:
Nature of above visit:_____
_____
Date of incident:_____ Time of incident: _____am/pm.
Where did incident occur? (home, work, other)_____
_____
How did incident occur? Please provide details:_____
_____
Was this incident related in any way to you work? yes/no
If yes, please explain:_____
_____
Was this incident the result of a third party? yes/no
If yes, name and address of third party:_____
_____
Do you plan to file a suit against the third party or submit the medical expenses to the third party's insurance? (such as homeowners, etc) yes/no
If yes, when?_____
_____
Signature/Date

Please submit the requested information within thirty days. Upon receipt of the requested information your claim will be processed in accordance to the health plan guidelines. Failure to submit all information will result in the filing of your claim.

Sincerely,

St. Lawrence-Lewis Insurances