Injury Report and File Status Request

Please use this form to:

- Report accidents
- Confirm if Humana provided benefits for an accident-related injury or illness
- Request final payment information needed to settle claims made against other insurance carriers and individuals

If you are contacting Humana on behalf of an enrollee/member, please submit an authorization signed by the enrollee/member or proof of representation with your request. Once we receive your inquiry, we will contact you for additional information and, if necessary, to confirm your authorization to receive information from Humana. Please note that an injury report is not complete until Humana finishes its review and confirms that we have enough information to make benefit processing decisions.

Note: Humana authorized Optum, Discovery Health Partners and SCIO Health Analytics to investigate paid claims and verify proper benefit processing whenever accident insurance coverage, workers' compensation or other individuals may be responsible for an accident-related injury or illness. If one of these companies has contacted you, you may wish to respond to them directly for faster service.

*** Denotes required field**

Tell us about you

I am* Please select one
If other, please specify
Name*
Email address*
Company*
Phone number*

Humana®

*** Denotes required field**

Tell us about the injured Humana enrollee/member

First name*		
Last name*		
Humana ID number **or** Medicare Beneficiary ID (MBI)*		
Street address*		
City*	State*	ZIP*
Date of birth (mm/dd/yyyy)*	Phone number	
Were other family members injured in this incident? ☐ Yes ☐ No		

Tell us about the accident-related injury or illness

Date of injury/onset of illness (mm/dd/yyyy)* (If you do not know, please provide an approximate date)
Accident type: Please select one
Other illness:
Briefly describe the cause of the accident-related injury or illness (For example, “patient slipped on wet floor” or “other driver ran red light”)
What kinds of injuries/illnesses resulted from the accident?* (For example, “broken arm,” “sprained neck,” etc.)

Tell us about other insurance that has made or may make payment

Carrier name*		
Has this carrier offered to make payment?* ☐ Yes ☐ No		
Type of insurance coverage Please select one		
If other, please specify		
Adjuster name	Phone number	

*** Denotes required field**

Name of policyholder	Claim number
Have other carriers been asked to make payment?* ☐ Yes ☐ No	

If you answered yes to the above, please fill in the following information:

Carrier name 2		
Has this carrier offered to make payment? ☐ Yes ☐ No		
Type of insurance coverage Please select one		
If other, please specify		
Adjuster name	Phone number	
Name of policyholder	Claim number	

Tell us about the injured Humana enrollee's/member's attorney

(If there is no attorney, please enter "N/A" in the required fields)

Attorney's name*	Law firm name*	
Firm street address		
City	State	ZIP
Phone number		
Email		

Is there anything else we should know or that you want to ask?

Please include authorization (e.g., letter of representation, signed authorization, court document, etc.) with your submission.

Questions?

If you have additional questions or need to supply additional information, please contact us:

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