

Transportation Accident Reporting Form

Please fill out the appropriate information below, save it for your files, and email the completed form to Trans-Prov@ucare.org or fax it to 612-676-6541.

PLEASE ATTACH COPIES OF ALL ACCIDENT REPORTS AND VIOLATIONS THAT WERE GIVEN AT THE SCENE OF THE ACCIDENT

OFFICE INFORMATION

Transportation Provider Name: _____

UCare Six Digit Provider Number (s): _____

Main Phone Number: _____ Main Fax Number: _____

Accident Contact Person's Name: _____

Accident Contact Email Address: _____

Accident Contact Phone Number: _____

MEMBER INFORMATION

Member Name: _____

Member ID: _____

HR or STS Authorization Number: _____

ACCIDENT INFORMATION

Date of the accident: _____

Location where the accident occurred (including street address and city or town):

The name and license information of the driver involved in the accident

The license plate and vehicle identification number of the vehicle involved in the accident

Number of passengers in the vehicle at the time of the accident

Number of injuries and/or fatalities

Description of the accident

Was the driver was convicted of a moving violation for driving conduct that led to the accident

Yes No

Additional Comments:
