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Accident/ Incident Report

Date of Accident/Incident: _____ Time of Accident/Incident: _____

Transportation Provider: _____ Date Reported: _____

Contact Person:_____Telephone #: _____

Address: _____ Fax #: _____

Driver of Provider's Vehicle: _____Driver's License #: _____

Make, Model & Year of Provider's Vehicle: _____

Vehicle Tag #: _____ VIN: _____

Vehicle Owner: _____Insurance Carrier: _____ Policy #: _____

Damage to Provider's Vehicle: _____

Driver of Other Vehicle: _____ Driver's License #: _____

Make, Model & Year of Other Vehicle: _____

Vehicle Tag #: _____ VIN: _____

Vehicle Owner: _____ Insurance Carrier: _____Policy #: _____

Damage to Other Vehicle: _____

Detailed Description of accident/incident (attach additional pages if necessary): _____

_____

_____

_____

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Accident and Incident Report

Check all that apply

Injuries: No _____ Yes _____ Minor _____ Serious _____ Fatal_____

Injured: Recipient(s) _____ Driver _____ Attendant _____ Escort ____ Other____

Name #1: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene _____ Medical Facility_____ Name Medical Facility _____

Brief Description of Treatment: _____

Name #2: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene _____ Medical Facility _____ Name Medical Facility _____

Brief Description of Treatment: _____

Name #3: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene _____ Medical Facility____ Name Medical Facility _____

Brief Description of Treatment: _____

Name #4: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene _____ Medical Facility _____ Name Medical Facility _____

Brief Description of Treatment: _____

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Were emergency services called? 911___ Police ___ Ambulance___ Tow truck ___ No____

If Motor vehicle accident, who was charged? _____

Attached: Police Report _____ Other _____

Report Submitted by: _____ Phone #: _____ Date: _____

Print/type name

Signature: _____

Provider: Do not write below this line. For MODV use only.

_____

_____

_____

_____

_____

_____

_____

Instructions for Accident/Incident Report Form:

Transportation Providers shall notify Modivcare immediately of any accident/incident/moving violation involving any of its drivers/vehicles while providing services for Modivcare (whether or not a member is in the vehicle at the time of the collision or accident). Please supply Modivcare with this form and any supporting documentation (such as a Police Report) as soon as possible and no later than 3 business days from the time of incident. Thank you in advance for cooperating with Modivcare during any ensuing investigation. Please ensure the drivers providing services for Modivcare keep a copy of this form in their vehicles.

If you have any questions about this form or your reporting obligations, please reach out to your Modivcare Provider Relations Team Member.