STATEMENT OF CLAIMANT

Name Street Address City State Zip Code	Home Telephone Number: Area Code Number ( )

Date of Birth	Social Security Number	Height	Weight	Right or Left Handed?

Name and Address of Employer

Alcorn State University, 1000 ASU Drive, Lorman, MS 39096

Wages Per Hour ( ) Per Month ( ) $ Per Week ( ) Per Day ( )	Hours Worked Per Day: Days Worked Per Week:	Regular Occupation	How Long Have You Worked For This Employer?

Date of Accident	Hour AM or PM	Place of Accident

Describe Exactly How The Accident Occurred (use back of sheet if necessary)

What Part of Your Body Was Injured? Describe Your Injury In As Much Detail As Possible.

Name of Your Immediate Supervisor	To Whom Did You First Report Your Injury? When?

Names, Addresses and Phone Numbers Of Any Witnesses

Name and Address of Your Doctor (#1) Who Selected or Chose This Doctor?	Name and Address of Your Doctor (#2) (Use back of sheet to list other doctors if necessary) Who Selected or Chose This Doctor?

Date of First Doctor Visit?	When Did You Last See The Doctor?	Are You Still Seeing The Doctor?	If Yes, When Is Your Next Visit?
What Date Did You Start Losing Time From Work?	Have You Returned To Work?	If Yes, Please Give Date	If No, When Do You Expect To Return to Work?

Have You Ever Hurt or Had Problems With This Part of Your Body Before? If Yes, Please Advise When, Where, and Other Details.

Have You Ever Filed A Workers= Compensation Claim Before? If Yes, Please Advise When, Where, and Other Details.

Are you currently a Medicare or Social Security Disability recipient?

Signed (Signature of Claimant)	Date

Medicare Eligibility

1. Are you currently a Medicare Beneficiary?

   Yes____ NO____

2. Have you ever applied for Medicare and been denied benefits?

   Yes____ No____

3. Have you ever appealed a denial of benefits to Medicare?

   Yes____ Date of Appeal: _____

4. Are you on Social Security Disability?

   Yes____ No_____

5. If you are a Medicare Beneficiary, do you have a Medicare Advantage Plan?

   Yes____ No____

6. Please provide a copy of your Medicare Advantage Plan card or complete the information below:

   Name of Beneficiary: _____
   Medicare Claim Number/HICN # _____
   Member ID #: _____
   Effective Date: _____

Please sign below to signify that the above information is correct.

_____
SIGNATURE

_____
DATE