Our records indicate that you or a family member may have experienced an accident or injury. To continue processing your claim, we need your answers to the questions below.
Please note, if we do not receive your answers within 45 days, the claim will be denied.

Was the medical treatment the result of an accident or injury?

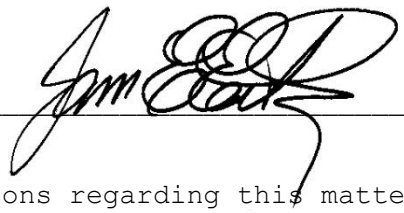
Yes _____ **No XXX** Date of injury (if applicable)

Please describe the accident or injury and medical treatment you received (if applicable)

If No, please explain reason for medical treatment
Terri passed out in public, bystanders called ambulance. Transported to Illini ER. Diagnosed with extremely low potassium. Treated and released.

If Yes, was the accident or injury:
Motor Vehicle Related _____ Work Related _____ Other _____
Did you file a report of injury? Yes _____ No _____

I certify that all information provided above is true and correct based on my knowledge and belief. I further understand that any misstatement or omission from this information may require me to reimburse Health Alliance any sum expended for services later determined to be the responsibility of another party. I further understand Health Alliance may terminate my rights and cancel my policy as of the initial effective date by reason of fraud.

(Signature Required)  (Date) ***5/31/2018***

If you have any questions regarding this matter, please contact our Customer Service Representatives at the telephone number listed on the back of your Health Alliance identification card. Once this information has been obtained, we will continue to process the claim accordingly. Again, if no response for the requested information is received within 45 days of this letter, the claim will be denied.

Thank you for your prompt attention to this matter.

Insured ID: 94100131702 (Terri Eatock)
Member:
James E Eatock
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Pittsfield, IL 62363
573-754-2113
jimeatock@yahoo.com