

Auto Injury Information

Patient Name: _____ Date of Injury: _____

Was the vehicle you were in at fault? Yes No Where you the driver? Yes No

Your insurance information: (Regardless of fault – this must be complete)

Insurance Company Name _____

Address _____

Phone No _____

Adjuster's Name _____

Phone No _____

Claim Number _____

Other Party Insurance information (if applicable)

Policy Holder's Name _____

Insurance Co. Name _____

Address _____

Phone No _____

Adjuster's name _____

Phone No _____

Claim number _____

Have you retained an Attorney? Yes No

Attorney name? _____

Attorney phone number _____

FOR OFFICE USE ONLY

Patient Insurance: _____

Is there med pay available for our patient? Yes No If so, can you tell me how much? \$ _____

What is the address to send the bills? _____

If there is not med pay available, call the other party's insurance co.

Is there med pay available? If so, can you tell me how much? \$ _____

If this claim is a "time of settlement" payment, will you issue the check directly to the doctor or the patient?

Where may we send bills? _____