Patient Name:_____
Date of Accident_____

AUTO ACCIDENT INSURANCE INFORMATION

(Please provide the following information to our office about your claim. With this information we will be able to forward your claims to the appropriate insurance company.)

LIABILITY INSURANCE: Claim No._____

Insurance Company Name_____

Address_____

City_____State_____Zip Code_____

Adjuster's Name_____

Phone No._____Fax No._____

MEDPAY INSURANCE: Claim No._____

Insurance Company Name_____

Address_____

City_____State_____Zip Code_____

Adjuster's Name_____

Phone No._____Fax No._____

PATIENT'S HEALTH INSURANCE (Please provide a copy of the insurance card)

Patient's Name_____Date of Birth_____

Insurance Company_____

Policy Number_____Group No._____

Send Claims To_____

_____