

Auto Accident Requirements

If your injury was due to an auto accident, you must provide us with the following information:

Were you the () driver, () passenger, or () pedestrian in the accident?

Where did the accident occur: _____

(City, State, Zip)

Is there a police report on file regarding this accident? () Yes () No

If yes, law enforcement branch: _____

Name of Organization

Name of Officer

If yes, law enforcement case #: _____

Is this accident being covered by () your automobile insurance, () the other parties automobile insurance or () both?

If this accident is being covered by another parties' automobile insurance, please provide us with the following information pertinent to that individual:

Name of Individual: _____

(Last Name, First Name)

Address: _____

(Physical Address or P.O. Box)

(City, State, Zip)

Phone: _____

(Please include area code)

Date of Birth: _____

(Month/Date/Year)

Please provide the following details regarding insurance coverage:

Name of Insurance Company: _____

(Business Name)

Address of Insurance Company: _____

(Physical Address/P.O. Box)

(City, State, Zip)

Phone Number Insurance Co. _____

(Please include area code)

Policy Number of Auto Insurance: _____

(Please include area code)

Claim Number for this Accident: _____

(Note: Claim number differs from policy #)

Date of Accident: _____

(Month/Date/Year)

State the Accident Occurred: _____

Name of the Subscriber: _____

Please Note: It is against office policy to bill an attorney's office. If you are having an attorney handle your litigation and you do not wish to have our facility bill the automobile insurance directly, we will register your account as self-pay with our facility and you will fall under those patient policies and requirements.