

AUTO INSURANCE CLAIM

AUTO INSURANCE: _____

ADDRESS: _____
STREET CITY STATE ZIP

CLAIM #: _____ **ADJUSTER:** _____ **PHONE#:** (_) _____

INSURED'S NAME: _____ **RELATION:** _____

ADDRESS: _____
STREET CITY STATE ZIP

HEALTH INSURANCE: _____

ADDRESS: _____
STREET CITY STATE ZIP

POLICY/SUBSCRIBER ID#: _____ **GROUP#:** _____

SUBSCRIBER'S NAME: _____ **RELATION:** _____

HAVE YOU RETAINED AN ATTORNEY? YES NO

ATTORNEY NAME: _____ **PHONE:** (_) _____

ADDRESS: _____
STREET CITY STATE ZIP

PLEASE NOTIFY OUR OFFICE SHOULD YOU AQUIRE AN ATTORNEY FOR THIS INJURY AS THE PATIENT/GUARDIAN IS SOLELY RESPONSIBLE FOR ALL INFORMATION REGARDING THIS CLAIM.

HOW DID YOU CHOOSE OUR FACILITY?

REFERRED BY: FRIEND FAMILY M.D. OTHER: _____

THANK YOU.