HEALTH/LIABILITY INSURANCE CLAIM

PRIMARY HEALTH INSURANCE: _____

ADDRESS: _____ PHONE: (____)_____
STREET CITY STATE ZIP

POLICY/SUBSCRIBER ID#: _____ GROUP: _____

SUBSCRIBER'S NAME: _____ RELATION: _____

SECONDARY HEALTH INSURANCE: _____

ADDRESS: _____ PHONE: (____)_____
STREET CITY STATE ZIP

POLICY/SUBSCRIBER ID#: _____ GROUP: _____

SUBSCRIBER'S NAME: _____ RELATION: _____

HOW DID YOU CHOOSE OUR FACILITY?

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

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? YES NO (CIRCLE ONE)

IF YES, NAME & PHONE # OF ATTORNEY _____

_____

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.

THANK YOU.