AUTO ACCIDENT CLAIM INFORMATION

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

You have informed us that you were in an auto accident. The following information is needed to process your medical claim.

- Name of your auto insurance company: _____
- Name of policyholder: _____
- Accident claim number: _____
- Adjuster name and phone number: _____
- Date of injury: _____
- Auto insurance medical claims billing address and phone number:

  _____

  _____

  _____

- **My auto insurance needs to be billed first:** ☐
- **My commercial insurance needs to be billed first:** ☐

The above information is needed to process your claim and submit it to your auto insurance. If you fail to provide the proper billing information to the office, this may result in denial of your claim and financial cost to you.

Thank you.