



Trinity Medical Associates

**Motor Vehicle Claim/Accident Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Claim number: \_\_\_\_\_ Date of accident: \_\_\_\_\_

Adjusters Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Brief **description** of accident, include **where accident** occurred and **injured body part**

By signing below, I acknowledge:

1. That all information rendered on this sheet is true and accurate to the best of my knowledge.
2. It is my responsibility to notify Trinity Medical Associates of any changes or updates that occur with this claim.
3. Visits involving this auto accident cannot be combined with any other health care visits.
4. All services rendered that are not covered under the auto accident claim will be my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_