Personal Injury Insurance Information

Please fill out completely. If we do not get this information by your second visit, you will be expected to begin paying towards your balance. If you have any questions about the status of insurance payments during or after your treatment, please ask.

Patient Name:_____Date of birth: _____

Claim Number:_____

Type of accident: _____Auto _____Other Accident

Date of Accident:_____

Is the following insurance information *your* insurance? YES NO

If not, the name of the insured (the other party involved in the accident), if known:

_____

Insurance Company information (full name and address from insurance card if possible):

_____

_____

_____

_____

Contact name at the insurance company: _____

Phone number we can reach them at:_____

To be filled out by office staff:

Date received: _____

Insurance contacted:

Date: _____ Name of contact: _____

Has this insurance accepted responsibility for the claim? YES NO

Do medical notes need to be sent with claims? YES NO

Address to mail claims to:

_____

_____

_____

_____

Is electronic billing available? YES NO If so, EDI Payor # for claims: _____