Auto Injury Billing Information

It is very important that we have as much of this information as possible

Policy Holder's Name: _____

Date of Accident: _____ **Was someone else at fault?** YES NO

Auto Insurance Carrier: _____

Claim Number: _____

Medical Adjustor's Name: _____

Phone Number: _____ **Address:** _____

Extension: _____ _____

Fax: _____ _____

MedPay Available? YES or NO

If no Medical Expense Coverage is available, would you want our office to bill your out-of-network health insurance benefits? YES or NO

***choosing YES will result in out of pocket expenses for deductibles and copayments to be collected at the time of service(s) are rendered.*

Health Insurance Carrier: _____

Insurance ID#:_____ Group#:_____

Provider Phone Number:_____

<u>Information about the other driver:</u>

Driver's Name: _____

Auto Insurance Carrier: _____

Claim number: _____

Bodily Injury Adjustor's name: _____

Phone number: _____ **Fax:** _____

Extension: _____

It is advised in the state of Virginia to have an attorney file your paperwork. If you do not have an attorney, please ask your doctor for a referral

Attorney's name: _____

Phone number: _____ Address: _____

Fax Number: _____ _____