AUTO INSURANCE CLAIM WORKSHEET

Patient Name: ____

Date of Birth: _______________________________ Date: ___________________

Date of Accident: _____________________________

City and State Accident Occurred: ____

Brief Description of Injury: ____

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Claim Information

Insurance Company Covering Claim: ____

Phone Number: ____

Billing Address: ____

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Claims Number: ____

Claim Adjuster's Name: ____

Phone Number: ____

Fax Number: ____

Attorney Information for Lien

Attorney's Name: ____

Attorney's Phone Number: ____

Attorney's Fax Number: ____

Please note: We will only be able to bill this claim if all required information provided is accurate. If information is inaccurate, it is your responsibility to provide us with the correct information, otherwise you will be responsible for all charges.