MOTOR VEHICLE ACCIDENT INFORMATION FORM

PLEASE READ THIS FORM CAREFULLY!!

You must notify your auto insurance carrier of injury or illness for this claim to be processed. **Failure to do so makes you personally responsible to pay for any treatment received!** All information below must be filled in accurately. This allows us to bill your auto insurance company for your accident related injury. If for some reason you do not have the necessary information to complete this form, please ask someone at the desk to allow you to use the phone in order to obtain the correct information from your adjuster.

Date of Injury: ______________________ Was this accident related? ______________

What state did the accident take place? ______________________

Where you the driver or the passenger? ______________________

Is this a PPO Plan? ______________ If so, which medical network? ______________

Automobile
Insurance Carrier: ____

Your Adjuster: ______________________ Phone: ______________________

Claim Number: ____

Billing Address: ____

City and State: ____

I have read and filled in the above information to the best of my knowledge. I understand that this information is necessary for the motor vehicle insurance carrier to pay for my account. I also understand that my failure to report this accident to my insurance company makes me personally responsible for this account.

Signed: ____

Date: ____