ACCIDENT-INJURY-SPRAIN-STRAIN

PATIENTS NAME/DOB _____ **ACCT#**_____

DATE OF INJURY _____

AREA OF BODY INJURED _____

WHERE ACCIDENT HAPPENED _____

HOW ACCIDENT HAPPENED _____

IS THIS THE RESULT OF MOTOR VEHICLE ACCIDENT? YES NO

If yes, Name, address and policy # of MVA Insurance Agency

_____

_____

_____

PHONE #_____

POLICY #_____

NAME OF MVA CARRIER IF KNOWN:

_____

_____

PHONE #_____

CLAIM # (IF HAVE ONE)_____

FOR OFFICE USE ONLY:

_____**(Biller name) contacted insurance agent/carrier and verified claim**

_____**(Date verified)**

_____**(Person contacted at agency/carrier)**

_____**(Reference number)**

PATIENT AUTHORIZATION:
I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

NAME:_____ **DATE:**_____