Work Comp or Motor Vehicle Accident Information

Information Needed

1. **Patient's name, Date of Birth _____**
2. **Claim number _____**
3. **Insurance Company name & phone #**

   _____
4. **Name of adjuster _____**
5. **Adjusters email address_____**

   fax_____

   phone number _____
6. **Where are claims sent?**

   Name of Company _____

   EDI _____

   Address _____

   City, State Zip _____

   Fax _____

   Email _____

7. **Date of accident _____**
8. **State where accident happened _____**
9. **How many visits are authorized _____**
10. **Managing Physician/Referring Physician Name_____**

    Phone number _____

    Fax number_____

Please bring this form with you to your appointment so that it can be scanned as part of your chart record. Please bring a photo ID to be scanned in as well.