

## Personal Injury Insurance Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_  Driver  Passenger At fault?  Yes  No

Please provide as much information as possible so your case can be set up properly. In the state of Arizona, insurance laws allow us to bill all insurance policies that have accident coverage. In the case of multiple types of insurance coverage, overpayment may occur. We only need to be paid once, so overpayments will be reimbursed when you are released from care.

\_\_\_\_\_ (Patient Initials)

**Third Party Liability:** This is the insurance information for the person who was in the "other car". The information can be found on the Accident Report.

Driver's Name: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Ph # \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

**Medical Payment Coverage:** On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Med-Pay". Med-pay is for injuries that occurred to anyone in the automobile. This insurance covers you if the accident was or was not your fault. **Using this portion of the policy cannot raise your premium or affect your record in any way.** In fact, this is exactly why you pay for "Med-Pay" on your insurance policy.

\_\_\_\_\_ (Patient Initials)

Claimant: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

\*\*\*\* The above information is printed on the proof of insurance card that is kept in the automobile. \*\*\*\*

**Health Insurance:** Health insurance maybe billed for treatment not covered by third party insurance or "Med-Pay".

**Billing your health insurance will not raise your individual rate or cause your insurance to be cancelled.**

\_\_\_\_\_ (Patient Initials)

Insured Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### **Attorney Information:**

Name: \_\_\_\_\_

Firm: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Ph #: \_\_\_\_\_

Office Initials: \_\_\_\_\_