AUTO INSURANCE VERIFICATION

Today's Date: _____

Patient's Name: _____ Phone #: _____

DOB: _____ SSN: _____

Auto Ins Co: _____ Phone #: _____

Mailing Address for Claims: _____

Claim #: _____ Policy #: _____

Contact Person/Team #: _____

Fax #: _____

Date of Injury: _____ State accident occurred in: _____

PIP: _____ Deductible: _____ Coinsurance: _____

Are there any benefits remaining? Yes _____ No _____

Does the patient have Med Pay? _____

Is there an attorney involved? Yes _____ No _____

Attorney Name: _____

Attorney Phone #: _____ Attorney Fax #: _____

Attention: _____

LOP Requested? Yes _____ No _____

Chief Complaint: _____

_____

X-Ray/MRI available? _____

Completed By: _____

5/18/2010