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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Delmarva%20Logo%20on%20Top%20(No%20Motto)%20copy%20black.png | **MOTOR VEHICLE ACCIDENT INTAKE FORM** | |  |  |  | | --- | --- | --- | |  | **Phone** | **(302) 355-0900** | |  | **Fax** | **(302) 355-0901** | |  | **Web** | delmarvapain.com | |

|  |  |
| --- | --- |
| **AUTO ACCIDENT INFORMATION** | |
| Patient’s Name: | Date of Birth: |
| **PLEASE PROVIDE THE FOLLOWING INFORMATION:** | |
| Auto Insurance Company: | |
| Address: | |
| Claim #: | Adjustor Name: |
| Date and State of Accident: | Adjustor Phone #: |
|  | |
| Briefly describe the accident and injuries: | |
|  | |
|  | |
|  | |
| If you have an attorney representing you on this case, please provide the following: | |
| Attorney’s Name: | |
| Attorney’s Phone Number: | |
|  | |
| In the event my claims are denied from the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable.  I understand that I am responsible for any payment of all services rendered should my claims be denied. | |
| Signature: **X** | Date: |