COMPASSIONATE FAMILY MEDICINE
NO FAULT INFORMATION REQUEST

Please make sure that you report the injury to your Employer (job) so that you are able to provide the following information. All medical bills must be submitted to the insurance carrier in a timely manner. If this cannot be done due to lack of insurance information, you may be held responsible for the balance due. Thank you for your cooperation.

MAKE SURE THAT YOU HAVE COMPLETED AND MAILED THE INSURANCE APPLICATION FORM TO YOUR NO FAULT INSURANCE CARRIER.

Patient Name: _____

Patient's Date of Birth: _____ Patient's Social Security Number: _____

Patient's Address: _____
(Street, City, State, Zip Code)

Patient's Phone Number: _____

Policy Holder's Name: _____

No Fault Insurance Company Name: _____

Insurance Company Address: _____
(Street, City, State, Zip Code)

Contact/Insurance Adjuster's Name: _____

Adjuster's Direct Telephone Number: _____Fax: _____

Date of Accident: _____

Claim Number (if known): _____

Have you informed your automobile insurance carrier of this accident? [ ] Yes [ ] No

Brief Description of how your injury occurred: _____

_____

_____

Body Part(s) Injured (Be Specific): _____

_____

Were you under the care of another physician, hospital or medical center for this injury?

[ ] Yes [ ] No If yes, please state where: _____

_____

_____