Coordination of Benefits Form

Dear Patient:

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company.

Please complete Sections 1, 3, and 4 of this form. **(Please complete Section 3 ONLY if AUTO ACCIDENT)**

Patient's Name: _____ Subscriber's Name: _____

Section 1:
Name of Specialist you are seeing today: _____Dr. Nomen Azeem_____
Date of Visit: _____ Referred by: _____
Is the reason for your visit due to injury caused by an accident? ___ Y ___N
If yes, date of accident/injury: _____
Where was the accident? ____Auto ____Work ____ School ____ Home____ Other: _____
How did the accident occur? _____
_____

Was a third party responsible for your injury? ____Y ____N If yes, please provide the following:
Name and address of individual or company: _____
_____
Name and address of attorney representing third party: _____
_____

Section 2: **Self ____**
Full name of subscriber: _____ Subscriber SS#: _____
Subscriber's Employer: _____ Subscriber's DOB: _____

Section 3: (COMPLETE IF THIS IS AN AUTO ACCIDENT)
Were you in your own vehicle? ___Y ___N If No, car owner's name: _____
Were you the driver? ___Y ___N Passenger's? ___Y ___N
Were you wearing a seat belt? ___Y ___N
Name and address of Insurance company: _____
Claim#: _____ Claim adjuster's name and number: _____

Section 4: **Insurance card copied ____**
Is your problem covered by any other insurances? ___Y ___N

To the best of my knowledge the statements above are accurate and complete and unanswered questions indicate they do not apply. My signature authorizes _____ Insurance to receive any and all information concerning claims filed by me or on the behalf to another insurance carrier.

Signature: _____ **Print Name:** _____

Date: _____