Billing Information for Auto Accident Claim Filing

Name of Patient: ____

Phone Number: ____

Date of Birth: ____/____/____ Date of Injury: ____/____/____

Auto/PIP Insurance Company: ____

Insurance Address: ____

Insurance Phone Number: ____

Policy Number: ____________________ Claim Number: ___________________

Policy Holder/Insured: ____

Claim Manager: ___________________ Phone Number: __________________

Health Insurance Company: ____

Insurance Address: ____

Insurance Phone Number: ____

Policy Number: _____________________ Group Number: __________________

Policy Holder/ Insured: _______________ Date of Birth: ____/____/____

Attorney Name: ____

Attorney Phone Number: ____

By signing below, I acknowledge that the information provided is correct and that there is no other insurance in effect at this time. I agree to pay all charges not covered by the above-listed insurance company(s).

Signature: ______________________________________ Date: ____/____/____