

# ATTACHMENT A

## ***AUTO INSURANCE INFORMATION***

Were you the person driving at the time of the accident? YesNo *Fill in all information*

Patient's auto insurance company or Driver's auto insurance, if patient was a passenger

Accident Claim # \_\_\_\_\_ Policy# \_\_\_\_\_

Adjustor's Name \_\_\_\_\_ Phone# \_\_\_\_\_

Date of Accident: \_\_\_\_\_

State accident occurred: \_\_\_\_\_

Other Party's Insurance Carrier: \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Claim # (if known) \_\_\_\_\_

It is this office's policy to bill the patient's auto insurance medical payments policy. It is then up to the liable party's automobile insurance policy to subrogate (refund) payment to the patient's insurance company.

## ***WORKER'S COMPENSATION INFORMATION***

Have you reported this injury to your employer? YesNo

Employer's name at time of injury: \_\_\_\_\_

Worker's Comp Insurance Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Claim # \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

## ***OTHER TYPE OF LITIGATION (SLIP&FALLS, ETC)***

Please give brief description of injury: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of insurance carrier: \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Policy# \_\_\_\_\_ Date of Injury: \_\_\_\_\_

## ***ATTORNEY INFORMATION***

Attorney's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact person (if different than attorney) \_\_\_\_\_