Multidisciplinary Pain Management & Regenerative Medicine

AUTO ACCIDENT INFORMATION:

Patient's Name: ____

Date of Injury: _______________ Date Auto Accident was reported to Insurance: ___________________

Name of Auto Insurance: ____

Name of Subscriber: ____

Claim #: ____

Policy #: ____

Adjuster's Name: ____

PIP Adjuster's phone number: _______________________________FAX#___________________________

Auto Insurance Billing Address: ____

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Amount of deductible: ______________ How much of deductible has been met? $_________________

How much is PIP? $__________________________ How much PIP is remaining? $ _________________

Insurance pays : __________________ % ;Patient is responsible for : __________ % of charges

Do you have MED pay? ☐ yes ☐ no If yes, how much is MED pay? $ _____________________

Do you have a secondary/Health Insurance? ☐ yes ☐ no

What is the name of that insurance? ____

Is authorization required for that insurance? ____

Do you have an Attorney? _________ If yes, Attorney Name ___________________________________

Phone # _______________________ Fax # __________________

______________________________ ________________________

Patient or Guarantor Signature Date

9145 Narcoossee Road, Orlando, FL 32827
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