AUTOMOBILE ACCIDENT INSURANCE VERIFICATION

Date Verified: _____

Check One: ❑ Medical Pay ❑ Liability ❑ Uninsured Motorist

Questions:
- Assignment Honored: ❑ yes ❑ no
- Assignment w/ea Billling: ❑ yes ❑ no
- Initial Billing: ❑ yes ❑ no

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Patient Name: _____

Insured's Name: _____

Insurance Company: _____

Address: _____

Policy Number: _____ Claim Number: _____

Date Of Accident: _____ Time: _____

Name Of Adjuster: _____ Phone: _____

Med Pay Amount (if applicable) $_____

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Attorney Name: _____

Address: _____

Phone: _____ Lien Signed? ❑ yes ❑ no

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Special Instructions/Informatino: _____

_____

_____

Entered By: _____