MOTOR VEHICLE ACCIDENT FORM

It is the patient's responsibility to provide Parkview Medical Clinic the following information. ***If this form is not filled out completely, the patient will be held responsible for the all charges.***

Please note if this information is incomplete or inaccurate, Parkview Medical Clinic will not be able to process the claim. ***Please also note that motor vehicle insurance claims tend to have a timely filing period of 6 months (meaning the sooner you get us this information, the easier it will be to process). Failure to provide this information timely will result in the bill being the patient's responsibility.***

At the time of each visit, the patient must make Parkview Medical Clinic aware of which visit(s) should be billed to workers compensation or automobile insurance, and which should be billed to their health insurance plan.

PATIENT NAME:_____

DATE OF BIRTH: _____

DATE OF ACCIDENT: _____

TYPE OF INJURY (i.e. hand, knee, back, etc.): _____

MOTOR VEHICLE INSURANCE COMPANY: _____

INSURANCE ADJUSTER NAME: _____

INSURANCE ADJUSTER PHONE #: _____

INSURANCE BILLING ADDRESS: _____

MVA CLAIM #: _____

FIRST DATE OF SERVICE FOR INJURY AT PARKVIEW: _____

DOCTOR FOR MVA SERVICE AT PARKVIEW: _____