Motor Vehicle Accident
Auto Insurance Information

Patient Information

Name_____ Birth Date_____

Street Address_____

City, State, Zip_____

Primary Telephone_____Alternate_____

Auto Insurance Information:

Name of Carrier_____

Claim Number_____ Policy Number_____

Claims Address_____

Adjuster's Name_____ Date of Injury_____

Telephone_____ Fax Number_____

Medical Payment allowance $_____ Portion Exhausted $_____

Briefly explain how accident occurred:

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I request that IMC process my billing through my MedPay insurance coverage. I authorize IMC to submit medical and billing information directly to my MedPay insurance provider. I understand that any services provided that are not covered through my MedPay benefit will be my own responsibility and will be due and payable at the time of service.

Signature_____

Date_____