

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:

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 _____