WEST SALEM FAMILY PRACTICE ASSOCIATES, LLC

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PATIENT NAME: DATE OF BIRTH:

Please provide our office with the motor vehicle insurance information of the vehicle ***you were in*** whether as the driver or a passenger. We do not bill third party insurance providers (the other vehicle's insurance).

Date of injury/accident:

Claim number:

Name of motor vehicle insurance carrier:

Medical billing address for this carrier:

Adjustor's name and phone number:

Policyholder or insured's name:

Policy ID number:

I hereby authorize the above insurance company to remit all payments directly to the providers at West Salem Family Practice Associates, LLC. I understand that any services I receive for this motor vehicle accident may not be covered by this motor vehicle insurance carrier. I agree that I am financially responsible for any services that my insurance carrier does not pay.

Signature Date signed