

Personal Injury Verification Form

Section 1 - Patient Data – this section must be completed.							
Patients's Name:	State Accident	Was a police report issued? If so,					
	Occurred In:	please provide a copy for the front					
Date of Birth:	Date of Accident:	desk. O Yes O No					
SS#:	Date of 1st. visit:						
Section 2 – Your insurance information- this section must be completed. If you have not opened your							
medpay account, please do so and inform us as to its limits.							
Policy Holder:	olicy Holder: DOB:						
Insurance Company:							
Policy #:	Claim #:						
Address:							
City:	State:	Zip:					
Adjuster:	Phone:	Fax					
Email:							
Accident Reported? O Yes O I	No Claim Opened? O Yes C	No Medpay Opened? O Yes O No					
		Medpay Limits:					
Section 3 – Adverse/Liable Party – complete this section if someone other than you is responsible for your							
accident/injury.							
Policy Holder:	DOB:						
Insurance Company:							
Policy #:	Claim #						
Address:							
Auui Ess.							
City:	State:	Zip:					
	State: Phone:	Zip: Fax					
City:		·					
City: Adjuster:	Phone:	Fax					
City: Adjuster: Email:	Phone:	Fax					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name:	Phone:	Fax					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney	Phone:	Fax					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City:	Phone:	Fax					
City: Adjuster: Email: Accident Reported? O Yes O I Section 4 - Attorney Attorney Name: Address:	Phone: No Claim Opened? O Yes C	Fax D No					
City: Adjuster: Email: Accident Reported? Yes Section 4 - Attorney Attorney Name: Address: City: Phone: Email:	Phone: No Claim Opened? O Yes C State: Fax:	Fax D No Zip:					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I	Phone: No Claim Opened? O Yes C State: Fax:	Fax D No Zip:					
City: Adjuster: Email: Accident Reported? Yes Section 4 - Attorney Attorney Name: Address: City: Phone: Email:	Phone: No Claim Opened? O Yes C State: Fax:	Fax D No Zip:					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I Office Use Date:	Phone: No Claim Opened? O Yes C State: Fax:	Fax D No Zip:					
City: Adjuster: Email: Accident Reported? Yes Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes Section Sect	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With:	Fax D No Zip: Email:					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I Office Use Date:	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With:	Fax D No Zip:					
City: Adjuster: Email: Accident Reported? Yes Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes Section Sect	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With:	Fax D No Zip: Email:					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I Office Use Date: Reference # Approved Denied	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With: Approval Details/Limitations:	Fax D No Zip: Email: (Allowed Conditions, DX, Injury, Visit#):					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I Office Use Date: Reference #Approved Denied Bill to:	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With: Approval Details/Limitations: Verify Contact Inf	Fax D No Zip: Email:					
City: Adjuster: Email: Accident Reported? Yes Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes Office Use Date: Reference #ApprovedDenied Bill to: Notes sent by fax: Yes No	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With: Approval Details/Limitations: Verify Contact Inf Fax #	Fax D No Zip: Email: (Allowed Conditions, DX, Injury, Visit#):					
City: Adjuster: Email: Accident Reported? Yes I Section 4 - Attorney Attorney Name: Address: City: Phone: Email: Accident Reported? Yes I Office Use Date: Reference #Approved Denied Bill to:	Phone: No Claim Opened? O Yes C State: Fax: No Spoke With: Approval Details/Limitations: Verify Contact Inf Fax #	Fax D No Zip: Email: (Allowed Conditions, DX, Injury, Visit#):					