ADVANCED physical medicine & therapy, ltd.

Personal Injury Verification Form

Section 1 - Patient Data – *this section must be completed.*		
Patients's Name:	State Accident Occurred In: ________	Was a police report issued? If so, please provide a copy for the front desk. ◯ Yes ◯ No
Date of Birth:	Date of Accident:	
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:	DOB:	
Insurance Company:		
Policy #:	Claim #:	
Address:		
City:	State:	Zip:
Adjuster:	Phone:	Fax
Email:		
Accident Reported? ◯ Yes ◯ No	Claim Opened? ◯ Yes ◯ No	Medpay Opened? ◯ Yes ◯ 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:		
City:	State:	Zip:
Adjuster:	Phone:	Fax
Email:		
Accident Reported? ◯ Yes ◯ No	Claim Opened? ◯ Yes ◯ No	

Section 4 - Attorney		
Attorney Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:
Email:		
Accident Reported? ◯ Yes ◯ No		

Office Use

Date:	Spoke With:
Reference #	
_____Approved ______ Denied	Approval Details/Limitations: (Allowed Conditions, DX, Injury, Visit#):

Bill to: Verify Contact Information Above is complete

Notes sent by fax:__ Yes__ No	Fax #
Lien Sent for third party and Attorney claims:	
Sent to:	Date & Initials:
Staff Member:________________	