Automobile Accident Insurance Information

Patient name: ______________________________________

Date: __________________

Primary Automobile Insurance

1. Responsible Party's Auto Insurance Company: __________________________________
2. Responsible Party's Auto Insurance Company Phone number: _____________________
3. Name on Responsible Party's Policy: ____
4. Responsible Party's Policy #: ____
5. Incident Claim #: ____
6. Adjuster Name Assigned to Case: ____
7. Phone Number for Adjuster Assigned to Case: __________________________________
8. Where to mail claims: ____

Patient's automobile Insurance (if different from responsible party)

1. Patient's Auto Insurance Company: ____
2. Phone Number for Patient's Insurance Company: ________________________________
3. Name on Patient's Policy: ____
4. Patient's Policy #: ____

Attorney information (if applicable)

1. Name of Attorney: ____
2. Address: ____

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3. Phone: ____