Motor Vehicle Accident (MVA) Information

Patient Name _____ Date of Birth _____

Date of Accident _____ Claim # _____

Address to Mail Claims to:

Name _____

Address _____

City/ State _____ Zip _____

Contact Name _____

Telephone Number _____

Read the following statements and sign at the bottom. We will not bill your MVA insurance unless this is signed.

I understand that it is my responsibility as the patient to provide accurate billing information.

If I do not supply accurate information, I understand the balance will be my responsibility until I do supply the information. Any lack by me to update with correct information for 2 months is treated like any bill and puts my account in jeopardy to go to collections.

If my claim has been outstanding for over 6 months, with no payment from my insurance, I understand that the claim will be turned over to my responsibility to pay and that I will have to seek reimbursement personally from my insurance.

Patient/ Responsible Party Signature _____

Date _____

Witness_____