PERRY PHYSICAL THERAPY, INC.

AUTO ACCIDENT

ACCORDING TO YOUR AUTO INSURANCE POLICY, IS YOUR HEALTH INSURANCE OR AUTO INSURANCE PRIMARY FOR MEDICAL SERVICES?

AUTO or HEALTH or UNSURE (circle one)

(if your Health Insurance is primary, please provide Health Insurance information on previous forms)

PATIENT: ____

NAME OF INSURANCE CARRIER: ______________________________________

CLAIM NO: ____________________ POLICY HOLDER: _____________________

DATE OF ACCIDENT: __________________

INSURANCE ADDRESS: _____________________________________
CITY, STATE, ZIP CODE: ____________________________________

CONTACT PERSON: _____________________ TELEPHONE: ________________

IN AN AUTOMOBILE ACCIDENT CASE, OUR POLICY IS THAT SERVICES MUST BE AUTHORIZED PRIOR TO BEIN RENDERED.

OTHER LIABILITY ACCIDENT

PATIENT: ____

NAME OF INSURANCE CARRIER: ______________________________________

CLAIM NO: ____________________ POLICY HOLDER: _____________________

DATE OF INJURY: __________________

INSURANCE ADDRESS: _____________________________________
CITY, STATE, ZIP CODE: ____________________________________

CONTACT PERSON: _______________________ TELEPHONE: ___________

BRIEF DESCRIPTION OF INJURY: ______________________________________
____

WHERE OCCURRED: ______________________ RESPONSIBLE PARTY: ____________

IN ALL ACCIDENT CASES, OUR POLICY IS THAT SERVICES MUST BE AUTHORIZED PRIOR TO BEING RENDERED.