Insurance Coverage Information

Medical Insurance:

Insurance Carrier: ______________________________ Phone: _______________

Policy Holder name: ______________________ Policy Number: ________________

Group Number: __________________

Workers Compensation Injury:

Employer: ______________________________ Work Number: _______________

Address: ________________________________ Supervisor: _________________

Was injury/accident reported to supervisor? Y / N Date: __________ Time: _________

Workers Comp Carrier: ______________________________ Policy #: __________

Carriers Phone: _______________ Adjuster: ______________________________

Claim Number: __________________

Auto / Personal Injury:

Do you have "Med Pay" on your Auto Policy: Yes / No Amount: $ _______________

Insurance Carrier Name: ______________________ Phone: _________________

Adjuster: ______________________________ Claim Number: _______________

Third Party Payer (other involved vehicle insurance)

Third Party (Person at Fault's) Name: ________________________ Ph: __________

THEIR Insurance Carrier: _____________________________ Ph: ____________

Address: ____

Adjuster: ____________________________ Claim Number: ______________

Patient Name: ______________________________________ Date: ___________