MOTOR VEHICLE ACCIDENT

BELLINGHAM ADVANCED MEDICAL IMAGING

Patient First and Last Name: _____

Date of Accident: _____ / _____ / _____

Patient's Auto Insurance: _____

Insurance Claim Number: _____

Insurance Address – Company Claims: _____

Street Address or P.O. Box

_____

City State Zip Code

Adjuster's First & Last Name: _____

Adjuster's Phone Number: (_____) _____ - _____

Are there medical payments or personal injury protection coverage? ☐ Yes ☐ No*

*If no, please provide:

Insurance Name: _____

Claim Number: _____ Group Number: _____

Insurance Address: _____

Street Address or P.O. Box

_____

City State Zip Code

DISCLAIMER: I understand that I am primarily responsible for payment of all charges and/or services rendered regardless of the status of my claim. I also understand that it is my responsibility to provide all necessary information needed for billing to Bellingham Advanced Medical Imaging.

By signing this form, I acknowledge this is only an estimate and understand the above statement.

Patient Signature: _____ Date: _____ / _____ / _____

FOR INTERNAL USE ONLY

Scan in with patient demographics. **Staff Initials:** _____

5.9.2018

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