DALEWOOD MEDICAL CENTER

Motor Vehicle Accident Information

Patient Name:______________________________ Date:_______________________________

Date of Accident:____

Reason for Visit:____

Insured's Name:____

Relationship to Insured:_____________________________________

Patient was _____Driver _____Passenger

Insurance Company:_____________________________________

Insurance Agent:____ Phone No.______________

Claim No.:________________________ Policy No.:__________________________

Adjuster's Name:_____________________________ Phone No.___________________

Adjuster Fax Number:_________________________

Name of Person Confirming Med Pay Coverage:____________________________________

Billing Address:____

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