Winfield Family Medicine

Motor Vehicle Accident Information Form

Date of Service: _____ Date of Injury: _____

Patient's Name: _____ Date of Birth: _____

Diagnosis: _____

Will you be going through your auto insurance to recover your medical expenses or through the other parties insurance: _____
Is the insurance company disputing claim? Yes or No
Is the claim pending approval? Yes or No

If you answered yes to one of the above questions payment for office visit is due at the time of service. You may submit your bill to the insurance company for reimbursement.

Insurance Name: _____

Insurance Claims Address: _____

Insurance Contact Name: _____

Contact Phone Number: _____ Fax: _____

Claim Number: _____

How Many Vehicles Were Involved In Accident: _____

If Information Is Incomplete Patient Will Be Responsible For Office Visit at The Time Of Service.

All Information Must Be Completed Prior To Seeing The Physician.
Must Submit With The Encounter Form and Scanned In The Patients Chart.