ALL STAR HEALTH
SPINE & SPORTS CARE

Insurance Information

Patient Name: _____ Date of accident: ____/____/____

Liability Insurance *(Insurance information of person who hit you / party at fault)*

Policy Holder: _____

Insurance: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Claim Number: _____

Adjustor: _____ Tel: _____ Fax: _____

Attorney Information

Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____ Paralegal / Contact: _____

Patient's Auto Insurance *(Insurance of vehicle you were in at time of accident)*

Policy Holder: _____

Insurance: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____ Claim Number: _____

Is Med Pay / PIP available on your policy? ☐ Yes ☐ No ☐ Unknown

Adjustor: _____ Telephone: _____ Fax: _____

Patient's Health Insurance

Primary Coverage Insurance: _____

Policy Holder: _____

Secondary Coverage Insurance: _____

Policy Holder: _____

As a courtesy to our patients, we can bill your health insurance(s) for this accident. However, please be advised that any unpaid balance including contracted adjustments, deductibles, co-pays, etc., will be due upon settlement of your claim. Please bill my health insurance(s): ☐ **Yes** ☐ **No** Please note that our office(s) will be placing a medical lien on your claim to notify the responsible party(ies) of any unpaid balances on your account (s).

Patient Signature: _____ Date: ____/____/____

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