Auto Insurance Claim Confirmation

Date: _____

Patient Name: _____

Insured: _____

Date of Accident: _____

Insurance Company: _____

CLAIM # _____

Adjuster Name/Phone#: _____

Coordinated Benefits? _____

Deductible: _____

Fax # To Send Claims: _____

Mailing Address: _____

_____

ICD 9 or ICD 10 (after 10/1/15) _____

Notes: _____

_____

_____

Completed by/Date: _____