MOTOR VEHICLE CLAIM INFORMATION REQUEST

Orthopedic Associates of Lancaster, LTD.

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ Email: _____

Date of Accident: _____

Injured Body Part(s): _____

**** If multiple body parts, list all and include side (left or right)*

Accident Information

Was this a motorcycle accident? **Yes** **No**

If motorcycle accident, are there medical benefits on the insurance policy? **Yes** **No**

Accident City/State: _____

Insurance Information (this must be the patient's auto insurance policy)

Policy Holder Name: _____

Policy Number: _____

Insurance Company: _____

Claim Number: _____

Claims Address: _____

_____

Adjuster Name: _____

Adjuster Phone: _____

After the motor vehicle insurance processes the claims, any remaining balances will be billed directly to the guarantor. For your claim to be sent to personal medical insurance, complete the following section:

Insurance Company: _____

Member ID: _____ Group ID: _____

Claims Address: _____

Back of Insurance Card

_____

Policyholder Name: _____

Policyholder/Subscriber - the person whose employer provides the policy as a benefit or person paying for the insurance premium

Patient's relationship to subscriber: **Child** **Self** **Spouse** **Other:** _____

RETURN THIS FORM WITHIN 10 DAYS OF RECEIPT TO ORTHOPEDIC ASSOCIATES OF LANCASTER
FAX: 717-327-2794 EMAIL: OALCLAIMINFO@FIXBONES.COM