Accident Information

Most insurance companies will not pay claims without specific accident information.

Please bring this completed form with you to your appointment and give it to the receptionist for billing purposes.

Patient Name: _____ Date of Birth: _____

Medical Insurance: _____

Medical Insurance Address: _____

Insurance ID#: _____ Group #: _____

Body part injured: _____ Date of Injury: _____

Was the injury
- □ Job related
- □ Motor vehicle related
- □ Sport related
- □ Other Please specify: _____

Where did accident happen? _____

Do you anticipate a party other than your medical insurance listed above to be responsible for part of all of your medical bills? □ Yes □ No

If yes --- who is responsible?

Auto – Workers Comp – Other Name: _____

Address: _____

Telephone: _____ Claim #: _____

Name of Insured: _____ Insured's DOB:_____

Note: The contract with home owner's insurance, auto policies and/or most third party payers is between the owner of the policy and the insurance company. For this reason, Yelm Family Medicine, PLLC does not bill these types of policies. Clinic staff will accept payment at the time of service and provide copies of the billing slips to submit for reimbursement.

Signature: _____ Date: _____