

# ACCIDENT REPORT

Patient Name:

Account

1. Date & time of accident:

2. Describe where and how the accident happened:

3. If this was a **MOTOR VEHICLE ACCIDENT**:

A. Was the patient the driver, passenger, or a pedestrian?

B. Name, address, and phone number of the driver:

C. Name, address, and phone number of the other driver, if any:

D. Did the police investigate?

E. If yes, please supply the name and address of the investigating police agency:

F. Name of the person, if any, cited for traffic violation:

G. Please give name, address, and phone number of your automobile insurance company:

1. Policy number:

2. Claim number:

3. Adjuster's name, address, and phone number:

H. Please advise the amount of personal injury protection (PIP) benefits available, if any:

I. Please advise if there are any no-fault benefits under your automobile insurance policy:

J. Please give name, address, and phone number of the other driver's automobile insurance company:

1. Policy number:

2. Claim number:

3. Adjuster's name, address, and phone number:

4. Have you consulted an attorney regarding legal representation?

Attorney's Name:

Address:

Telephone number:

5. Does the patient have any medical insurance that covers this accident?

Insured's Name:

Insurance company name and address:

Policy Number:

Group Number:

Please feel free to add or include any additional information or comments that you feel might help us in servicing your claim:

I hereby certify that the above information is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_

Date