Osteopathic Healthcare of Maine

MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name: _____DOB:_____ **Claim #**:_____

Auto insurance carrier:_____ Policy holders name:_____

Adjusters name:_____ Telephone #:_____ Fax:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Was patient driver or passenger? _____ Type of vehicle involved (Car/Truck/SUV/Van): _____

Was accident due to other vehicle/animal/pedestrian/bicycle/other? :_____

Date of accident: _____ Is med pay available?: _____ Amount:_____

Osteopathic Healthcare of Maine has implemented a specific protocol for motor vehicle accidents.

1) Our office will bill the patient's auto insurance carrier as the primary insurance. Signing this form will authorize this company to issue payment directly to our office.

2) If your auto insurance med pay becomes exhausted, we will automatically bill your private health insurance. You will be responsible for any co-payments and deductibles per your policy. If you do not have private Health Insurance, payment for your visit is due at your appointment.

3) If an attorney has been retained, a letter of protection will be requested and sent to Osteopathic Healthcare of Maine. Attorney: _____ Phone:_____

This is an irrevocable assignment of benefits. This office does not wait for the time of settlement.

Auto insurance companies occasionally forward the payments to you or your attorney. We ask that those payments be immediately forwarded to our office. It is also important to understand that we only bill one insurance company for our services. If your auto insurance company has paid the claim, we will not bill your private health insurance for the same claim. We will only forward to your private insurance company if your medical payments are exhausted, or claims are denied.

If any balance remains at the time of your settlement, we ask that your attorney pay the balance directly to our office. Our office does not negotiate the remaining balance based on your settlement.

We ask you to sign this form showing that you understand and accept our office policies.

Signature: _____ Date: _____

A copy of this letter will be forwarded to your attorney/insurance carrier.

Reviewed by:
Staff Initials _____