



Bringing ER expertise to life's little emergencies

2040 Boston Road, Wilbraham MA 01095
Phone 413-599-3800 – Fax 413-279-1900

AUTOMOBILE INSURANCE INFORMATION PAYER FORM

Motor Vehicle Accident Information

Please complete this form to the best of your knowledge. Additional information can be furnished after your visit, however we need adequate information at time of service to ensure proper billing. Health insurance information is also obtained and may be billed secondary to the auto insurance policy.

PATIENT INFORMATION [Please print NEATLY & LEGIBLY]		
FIRST	LAST	DOB / /

Automobile Insurance Carrier Name	Claim #	
Claim Address:	City: State: Zip Code:	
Policy Holder Name <input type="checkbox"/> Same as patient	Policy Holder DOB	Policy #

Claim Adjuster Name	Their Contact Number: () - Ext
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DATE OF ACCIDENT / /	TIME OCCURRED : <input type="checkbox"/> AM <input type="checkbox"/> PM	# OF VEHICLES INVOLVED
Exact Location:	City: State: Zip Code:	
Intersecting Street (if applicable)	Your involvement in accident: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Cyclist	

Notes or other pertinent information helpful to properly bill responsible party

X _____ Patient Signature _____ Parent/Guardian Signature _____ Relationship to Patient