MOTOR VEHICLE ACCIDENT CLAIMS

Burnsville Family Physicians will submit charges to your no fault insurance carrier. You are required to provide us with the policy number, claim number, and a complete billing address. This does not mean that we are accepting the insurance company as the responsible party responsible for payment of services rendered. You, the patient/responsible party, are ultimately responsible for your bill.

If your claim is not paid within thirty days you are expected to make payment.

Date: ____________ Patient's Name: ____
Driver's License #: ________________

Automobile Insurance Information

Subscriber's Name: ____________________________ Birth Date: __________________
Policy Number:______________________ Claim Number: _______________________
Date of Injury________________________ State of Accident______________________
Insurance Companies Phone Number: ___________________
Auto Insurance Name: ____
Insurance Company Address:____
____
Insurance Agent's Name: ____
Patient's Relationship to the Subscriber ____ Self ____ Spouse ____ Depend ____ Other

Please sign and date:
Date: __________________ Signature: _______________________________________

Third Party Liability

Burnsville Family Physicians does not file for, or become involved in the resolution of, any third party liability claim. You, the patient/responsible party, are ultimately responsible for your bill.

Date: ____________
Name:____ SS#: ______________ Sex: ____M____F
Birth Date:_____________
Address:_________________________________ Apt #:_________ Home Phone(____)__________
City/State: __________________________________Zip: __________ Work Phone(____)_________
Email address:_______________________________ Fax:(___)__________________
Best Number: (___) ______________________________ Best time to reach: ______________________
Employed By: _________________________________Occupation/Dept:______________________
Employer's Address:_______________________________City__________________Zip_________
Employment Status: __Full-time __ Part-time ___Retired __ Full-time Student __Part-time Student

Please sign and date:
Date: __________________ Signature: _______________________________________
Updated 12/9/05