CONGENIAL HEALTHCARE,LLC

Essential Information for Workers Compensation and Motor Vehicle Accidents

MVA ☐ Workers Comp ☐

Patient Name: _____

Patient DOB: _____

Name of Insurance Company: _____

Date of Accident/ Injury: _____

Claim #: _____

Contact Person at Insurance Comp, or employer: _____

Phone # of Insurance Company: _____ _____

Fax # of Insurance Company: _____

Mailing Address for Billing: _____

_____

_____

Patient Signature: _____Date: _____

AUTHORIZATION FORM MUST BE FILLED OUT AND SIGNED BY PATIENT IF MOTOR VEHICLE ACCIDENT