



SPECIAL CLAIMS SITUATIONS:

Motor Vehicle Insurance:

Patient Name _____ Date of Birth _____

Date of Accident _____

Location of Accident _____

Motor Vehicle Ins Co _____

Address _____

Phone # _____

Policyholder Name _____ Date of Birth _____

Policy # _____ SS# _____

Claim # _____ Adjustor _____

Does your motor vehicle insurance have medical payment coverage?

_____ Yes: Benefit amount \$ _____

_____ No : Please have your insurance co fax "No Med Pay" letter to us.

Please complete and return all information to:
Michael Baroody, MD or fax: 203-797-1630