

Verification of insurance for MVA

Name: _____ Today's Date: _____

Is Accident Related to: Auto Other: _____

Date of Injury: _____ Place of Injury: _____

Relationship to Insured: Self Spouse Child Other: _____

Auto Insurance Company: _____

PIP Insurance Claim Number: _____

PIP Claims Adjuster Name: _____

Phone Number: _____ Ext: _____

Do you currently have another accident claim open? No Yes

If Yes, list date(s): _____

Who is the "At Fault Party" responsible for the accident? Self Other Split

Name of At Fault Party (if other than yourself): _____

At Fault Party's Car Insurance Company: _____

Personal Injury Representation

Attorney & Law Firm's Name: _____

Phone: _____ Fax: _____

Please read the following statements

- I have the option to pay for treatments at the time of service.
- Spa Remedease is authorized to directly bill the company which holds my PIP medical claim, and send copies of chart notes to receive reimbursement for services rendered.
- I understand that all fees are to be paid in full; Spa Remedease does not accept reduced "usual and customary" payments. Any unpaid amount will become my responsibility and must be paid within 90 days of notification.

Patient's or Guardian's Signature: _____ Date: _____

For Office Use Only

Verified by: _____

Date: _____

Do they have an open PIP? _____ What's the PIP amount? \$ _____

PIP Claim Billing Address: _____

City

State

Do the need special authorization massage? _____

Comments

