

# INSURANCE STATUS— PERSONAL INJURY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ ID#/DOB \_\_\_\_\_

## A. Reporting to Attorney

Which information would you like to receive monthly and how do you prefer to receive information:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> copies of billing  | <input type="checkbox"/> fax          |
| <input type="checkbox"/> monthly statements | <input type="checkbox"/> mail         |
| <input type="checkbox"/> SOAP charts        | <input type="checkbox"/> email        |
| <input type="checkbox"/> Progress reports   | <input type="checkbox"/> upon request |

## B. Primary Insurance Coverage

 Effective dates: from \_\_\_\_\_ to \_\_\_\_\_

Please provide the following information regarding your client's/my patient's insurance status:

Insured \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Adjuster \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

PIP policy amount \$ \_\_\_\_\_

Dates of coverage \_\_\_\_\_

PIP available \$ \_\_\_\_\_

Med Pay policy amount \$ \_\_\_\_\_

Dates of coverage \_\_\_\_\_

Med Pay available \$ \_\_\_\_\_

## C. Secondary Insurance Coverage

 N/A  Effective date: \_\_\_\_\_

Insured \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Adjuster \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

PIP policy amount \$ \_\_\_\_\_

Dates of coverage \_\_\_\_\_

PIP available \$ \_\_\_\_\_

Med Pay policy amount \$ \_\_\_\_\_

Dates of coverage \_\_\_\_\_

Med Pay available \$ \_\_\_\_\_

If secondary coverage is through the patients' private health insurance, is manual therapy a covered benefit:  Yes  No  Don't Know

## D. Third Party Insurance Coverage

 N/A  Effective date: \_\_\_\_\_

Insured \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Adjuster \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Liability policy amount \$ \_\_\_\_\_

Dates of coverage \_\_\_\_\_

Liability available \$ \_\_\_\_\_

Uninsured/underinsured Motorist (UIM)\$ \_\_\_\_\_

Policy Amount \$ \_\_\_\_\_

UIM available \$ \_\_\_\_\_