Chart # ____________________

CMFP

CODDINGTON MEDICAL FAMILY PRACTICE

Motor Vehicle Accident/Worker's Comp Injury

Patient Name: ______________________________ Date of Birth: ____________________

Date of Accident/Injury: ______________________________

Location of Accident/Injury (Please be Specific): ______________________________

____

Details of Accident/Injury: ______________________________

____

____

____

____

Employers Name (Worker's Comp Only): ______________________________

Claim #: ______________________________

Auto/WC Insurance Company: ______________________________

Insurance Auto/WC Address: ______________________________

Adjustor Name: ______________________________

Adjustor Phone #: ______________________________

Adjustor Fax # ______________________________

****AFTER BILLING IS COMPLETE YOU ARE RESPONSIBLE FOR WHAT INSURANCE, INCLUDING MEDICARE, MEDICAID, MOTOR VEHICLE INSURANCE OR WORKMAN'S COMP DOES NOT PAY****

This may include (but is not limited to) lab work (LabCorp/pathology medical), X-rays (AMI Radiology Associates), and anything else that requires a separate bill.

Patient Signature: ______________________________ Date: ____________________

Clinic Rep Signature: ______________________________ Date: ____________________