TriValley Primary Care

Must be completed by all patients/guarantors with injuries related to an Automobile accident

Automobile and Casualty Insurance Data Worksheet

If your injuries are due to an automobile accident, Pennsylvania law requires that we bill your Automobile Insurance Carrier. (Please use this same form if the accident is covered by a homeowners policy.) If your auto (or casualty) insurance denies the claim, we will submit it to your health insurance company. TriValley Primary Care will not hold claims pending litigation after a denial is received. Note: Any balance not adjusted by law or contract after Auto and Health Insurance coverages pay is the patient's/guarantor's responsibility.

Patient's Name: _____

Guarantor's Name (if different): _____

Patient's Address: _____

_____

Daytime Phone: (_____) _____ - _____ Evening Phone: (_____) _____ - _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Auto (Casualty) Insurance Company: _____

Insured's Name: _____ Policy Number: _____

Address for claims : _____

_____

Carrier's Phone: (_____) ____ - _____ Claim Number: _____

Agent's Name: _____ Agent's Phone: (_____) ____ - _____

How did the accident occur? _____

_____

Date of accident: _____ Time: _____ (AM/PM)

Have you informed your carrier? ☐ Yes ☐ No

IF YOU HAVE NOT REPORTED THIS INJURY TO YOUR AUTO INSURANCE CARRIER, YOU MUST DO SO AT ONCE!

Health Insurance Company*: _____

Address for Claims*: _____

Phone Number*: (_____) _____ - _____ * Attach copy of card if not on file

Health Insurance ID#*: _____ Group#*: _____

The above is true and accurate to the best of my knowledge.

_____ _____

Signature (Patient's or Guarantor's) (SEAL) Date

TriValley Office Instruction: PROVIDE PHOTOCOPY OF COMPLETED FORM TO PATIENT/GUARDIAN

"A Community of Physicians…for the Community"

Print Form