No-Fault and Third Party Form

PLEASE PRINT CLEARLY

Name: _____ Date: _____ DOB: _____

Third-party Information:

Third-party Insurance Company: _____

Claim Number: _____

Policy Number(if applicable): _____

Adjuster or Nurse Case Mgr Name/Number: _____

Injured body part: _____

Date of Accident: _____

Briefly describe what happened: _____

_____

_____.

Do you have regular insurance? Yes____ No ____

If yes:

Insurance type: _____

Insurance number: _____

Subscriber's Name/DOB: _____

(Please note we ask for your insurance info because if your funds are EXHAUSTED then we will bill your insurance. If you DON'T have insurance then you will be RESPONSIBLE for the bill)

Do you have an attorney? Yes ____ No ____

If yes:

Attorney's name: _____

Attorney's address: _____

Attorney's phone: _____