Auto Insurance PIP Information

The following information is necessary in order for our office to verify and bill your auto insurance carrier for services under the Personal Injury Protection (PIP) clause of your policy. **Please complete this form and return it to our office prior to your first visit.**

Insurance Information

Insurance Company: _____

Insurance Billing Address: _____

City: _____ State: _____ Zip: _____

Billing Fax #: (_____) _____

Policy #: _____ Claim #: _____

Claims Agent: Last: _____ First: _____

Agent's Direct Phone: (_____) _____

Amount of available PIP coverage: $_____

Have you seen anyone else for this problem? □ Yes □ No

If "Yes", please explain. _____

_____

Patient Information

First: _____ Middle:: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Date of Birth: _____ Gender: □ Male □ Female

Relationship to Insured: □ Self □ Spouse □ Child □ Other

State where accident occurred: _____

Insured's Information (if other than self)

First: _____ Middle:: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Date of Birth: _____ Gender: □ Male □ Female