

## Personal Accident/ Injury Insurance Information Form

After completing the document, please return via mail within 7 days.

**Patient Information**

Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Last 4 of Social Security Number: \_\_\_\_\_  
 Date Of Service: \_\_\_\_\_  
 Medical Record #: \_\_\_\_\_  
 Guarantor #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_  
 Type of Injury/ Body Part Injured (Be Specific): \_\_\_\_\_  
 State Accident Occurred In: MN WI ND MI  
Other (Please Specify What State): \_\_\_\_\_

**\*To Ensure proper processing of the charges related to this injury, please check one or more of the applicable boxes listed below\***

I do have auto/liability insurance coverage for my injury (Complete Section A)  
 I do not have auto/liability insurance coverage for my injury (Complete Section B)  
 I was injured while riding on: \_\_\_\_\_ (Motorcycle, ATV, Snowmobile etc.)  
 A liability claim is pending with my attorney  
 Attorney's Name: \_\_\_\_\_

Attorney's Number: \_\_\_\_\_  
 Injury benefits are on a coordination of benefits, excess basis. Services must be submitted to my personal health insurance carrier for payment first. (Complete section A & B)  
 Other (Please Specify): \_\_\_\_\_  
 Print Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

**Section A: Liability Insurance information**

*If you have insurance information such as auto, Home Owners or any other insurance coverage that is not your own personal health insurance that should be billed first, please list the following information:*

*Note: MN Auto Accidents- Minnesota is a "No fault" State. This means that YOUR OWN automobile insurance is the primary payer for medical costs associated with an auto accident. WI Auto Accidents- Wisconsin is an "At Fault" state. The insurance of the driver determined to be at fault by a law enforcement agency may be liable for the injuries or any person who was involved in the accident. A Wisconsin resident has the option of billing either their own insurance or their personal health insurance for medical expenses.*

Policy Holder's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Relationship between Patient/Policy Holder (Be specific): \_\_\_\_\_

Insurance Company name: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Claim Adjuster's Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
 Claim Number: \_\_\_\_\_

**Section B: Personal Health Insurance Billing Information**

Primary Insurance Company: \_\_\_\_\_  
 Claim Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Effective Date of Policy: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Policy ID Number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_

**Secondary Health Insurance Billing Information:**

Secondary Insurance Company: \_\_\_\_\_  
 Claim Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Effective Date of Policy: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Policy ID Number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_

**I hereby authorize Duluth Family Medicine Clinic to release information and medical records to the TPL insurance company listed for the payment of all related medical services regarding the Date of Injury above. Should the TPL insurance company deny payment for the claims, we will submit the denial and a new bill to your health insurance carrier.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Form may be mailed/faxed to the following:** Duluth Family Medicine Clinic  
 330 N 8<sup>th</sup> Ave E  
 Duluth, MN 55805  
 Phone: 218-723-1112  
 Fax: 218-529-9129