AUTO ACCIDENT CLAIM INFORMATION FORM			
LAST NAME	FIRST NAME		DATE OF BIRTH
DATE OF ACCIDENT	LOCATION OF ACCIDENT (STATE)	RESPONSIBLE PARTY	ACCIDENT CLAIM NUMBER
AUTO INSURANCE COMPANY NAME	AUTO INSURANCE COMPANY ADDRESS (CLAIM SUBMISSION)		
ADJUSTER NAME	ADJUSTER PHONE NUMBER	ADJUSTER FAX NUMBER	

Cedar Point Health's policy for care related to Motor Vehicle Accidents (MVAs) is that the top part of this form is completed in its entirety PRIOR to an appointment OR payment at the time of service will be required. Health insurance will not typically pay for injuries related to MVAs. It is the patient's responsibility to provide the appropriate insurance information or to pay in full at the time of service. If, for some reason, the Auto Insurance reimburses Cedar Point Health at a later date for a visit you paid for out of pocket, we will promptly reimburse you.

ACKNOWLEDGMENT

Please review and check the section below that is applicable to you.

- ☐ I have provided accurate Motor Vehicle Insurance information above related to the injury for which I'd like to be treated. I understand that if the insurance does not pay within 90 days, I will be responsible for the bill.

OR

- ☐ I will pay in full for my visit today

PATIENT NAME (PRINT) _____ SIGNATURE _____ DATE _____

PERSON SIGNING ON BEHALF OF PATIENT _____ RELATIONSHIP TO PATIENT _____