Pinnacle Physicians Group

WORKERS' COMP/AUTO ACCIDENT

NAME: _____ DOB: _____

DATE OF INJURY/ACCIDENT: _____

CLAIM NUMBER: _____

INSURANCE COMPANY & ADDRESS:
_____
_____
_____
_____

INSURANCE COMPANY PHONE #: _____

ADJUSTER NAME: _____
PHONE #: _____

STATE IN WHICH INJURY/ACCIDENT OCCURRED: _____

PERSONAL MEDICAL INSURANCE COMPANY: _____
INSURANCE ID NUMBER: _____

IN THE EVENT MY INSURANCE WILL NOT COVER THE CLAIM, I REALIZE THAT I AM RESPONSIBLE FOR PAYMENT IF I HAVE NO OTHER COVERAGE.

SIGNATURE: _____ DATE: _____