If your injury is an Auto Accident and/or Workers' Compensation claim- please fill out the following information.
Authorization is required before you can be seen in our office.

	Please circle:	
Was your injury caused by a **Work** related incident?	Yes	No
Was your injury caused by an **Auto** accident?	Yes	No

Patient Name _____

Claim# _____

Insurance Company Name _____

Billing address _____

_____

Claim Adjusters' Name _____

Phone number _____

Letter of Authorization Yes No

Letter of Dispute Yes No

For Auto Accident – Coordinated or Non-coordinated
(Coordinated= Medical ins. is primary-Non-Coordinated= auto ins. Primary)

Could this injury result in a liability claim? Yes No

/wcoraaform1207