ATLANTIC COAST MEDICAL CARE, L.L.C.

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In order for our office to expedite your requests, please provide below the contact information for your Attorney (Lawyer [if you have one], Case Manager, and any other person(s) pertinent to the case):

Law Firm: ______________________________
Address: ______________________________
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Attorney: ______________________________
Phone: ______________________________
Fax: ______________________________

Case Manager: ______________________________
Phone: ______________________________
Fax: ______________________________

Additional Information: ______________________________
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Insurance Company: ______________________________
Phone: ______________________________
Fax: ______________________________

Adjustor:______________________________
Phone: ______________________________
Fax: ______________________________

Claim Number:______________________________

____
Patient Printed Name

____
Patient Signature

____
Date

______________________________ ____________
Witness Date