Fischer Family Medicine, P.A.

MOTOR VEHICLE ACCIDENT FORM

Patient Name_____ D/O/B_____

Motor Vehicle Insurance_____

Motor Vehicle **Medical Billing Address**_____

_____

Motor Vehicle Insurance Contact_____

Motor Vehicle Insurance Phone #_____

Claim #_____ Date of Accident_____

Do you have medical insurance?_____
Have you selected your medical insurance as primary over your auto insurance in an MVA claim?_____
(If yes to either question, please make sure your medical insurance information is listed on your Patient Registration Form)

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By signing below, I acknowledge that I am financially responsible for any or all services rendered for which my insurance denies. I also acknowledge that it is my responsibility to obtain authorization for services rendered.

Patient Signature_____
(Parent/Guardian if patient is minor)

Date_____

FFM Employee Initials:_____