1702 Ohio Ave
Lynn Haven, FL 32444

COASTAL URGENT CARE

Ph: (850) 571 – 5844
Fax: (850) 571 – 5845

Patient: _____ Adjuster: _____

Patient Ph #: _____ Adjuster #: _____

Patient DOB: _____ Ins. Co: _____

Claim #_____ DOI: _____

Have all benefits been exhausted: _____ Ins. Address: _____

Has patient been seen for this injury somewhere already? _____

{ } **The Federal Gramm-Leach-Bliley Act requires a signed Authorization from the insured to release any non-public personal information. Please accept this letter as authorization for release of benefit information.**

Please check appropriate coverage:

{ } PIP and MP Payments

{ } PIP only at 80%

{ } MP only at 20%

{ } PIP Deductible Amount $ _____

{ } PIP is exhausted, MP pay 100%

{ } Major medical insurance for secondary insurance

Ins. Name: _____

Policy #: _____

Policyholder: _____

Policyholders DOB: _____

Policyholder Address: _____

We will provide you with the following information regarding treatment of this patient:

1. Notice of initiation of treatment and first DOS
2. Medical reports for all care rendered
3. Diagnosis
4. Prognosis
5. Length of anticipated treatment
6. Type of care recommended
7. Copy of patient's admission form
8. A copy of your assignment of benefits and HIPAA form

Estimate of Charges:_____

Patient's Signature: _____ **Date**: _____

Employee Signature: _____ **Approved By**: _____

updated 2/20/2018