

LANCASTER MEDICAL NO FAULT INFORMATION

Please fill in the following information **completely**:

Date: _____

Patient Information

Name _____

Date of birth _____ Social Security# _____

Address _____ City _____ State _____ Zip _____

Auto Insurance Information

In the event that the following information is not furnished completely, the charges will be mailed to you directly. We cannot bill your primary insurance carrier for No Fault related injuries. PLEASE RETURN THE APPLICATION OF BENEFITS TO YOUR NO FAULT CARRIER WITHIN 30 DAYS OF ACCIDENT, OR ELSE YOUR CLAIMS WILL NOT BE COVERED.

Insurance Company _____ Phone _____

Carrier Address _____ City _____ State _____ Zip _____

Name of Policy Holder _____ Relationship to Policy Holder _____

Date of birth of Policy Holder _____ Policy Number _____

Claim Number _____

Do you have a deductible for Medical? Yes ___ No ___ If yes, Amount _____

Accident Information

Date of Accident _____ Time _____ AM ___ PM ___

Type of injury(ies) sustained _____

Brief description of how accident occurred (if known) _____

Have you seen another physician for this condition? Yes ___ No ___ If yes, doctor's Name _____

Have you lost any time from work due to injury? Yes ___ No ___ If yes, What dates? _____

Have you ever had the same or similar injury? Yes ___ No ___ If yes, What dates? _____