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)____

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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?______________________

Please complete 2nd page of No Fault Paperwork