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Insurance Claim Form

1. Patient's Name _____ SS# _____
2. Date of Injury _____
3. Claim or Case # _____
4. Type of Insurance: ____ Auto ____ Work Comp

   If work comp, employer name at time of injury _____

   _____ Phone # _____
5. Name of Person INSURED, if other than you:_____
6. Your relationship to the person Insured (wife/husband/sister/friend, etc)

   _____
7. Name of the Insurance Company, Address, Phone Number

   Name _____

   Address _____

   City, State Zip _____

   Phone Number _____
8. Name of Your Claims Representative _____
9. Claim Rep's Phone # _____
10. Referring Physician Name, Address, Phone Number

    Name _____

    Address _____

    City, State, Zip _____

    Phone Number _____