



MOTOR VEHICLE/WORKMANS COMPENSATION

Please check what you are filing for:

- Motor Vehicle Case Workman Compensation Claim

You must supply our office with all the information pertaining to your claim within 3 days of your office visit. If you fail to provide the information, you will be billed for the visit.

List of Information you need to provide to office:

- Insurance Cards (Auto and Healthcare)
- Driver License
- Police Report
- Signed Assignment of Benefits
- Completed Accident Information Sheet

Accident Information

Patient's Name:	DOB:	Date of Accident:
Place of Accident:		
Name of Insurance Company (Auto/Workman Company):		
Billing Address for Insurance Company:		
Claim #:	Policy #:	
Adjustor's Name:	Phone #:	Fax #:
Lawyers Name:	Phone #:	

Were you taken to a hospital? **Yes No** If yes, name of hospital and city? _____

Were x-rays taken? **Yes No**

Were you admitted to the Hospital? **Yes No** If yes, what date(s)? _____

Please describe in detail how the accident happened.

Assignment of Benefits

Patient's Name: _____ D.O.B: _____

I irrevocably assign to Internet Medical Group, PC all my rights and benefits under any insurance contracts for payment for services rendered to me by IMG. I irrevocably authorize all information regarding my benefits under any insurance policy relating to IMG. I irrevocably authorize IMG to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to IMG. I irrevocably authorize IMG to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effects.

Signature of Patient: _____ Date: _____