TRI-CITY RADIOLOGY

Billing Information for Auto Accident Claim Filing

Name of Patient: _____

Phone Number: _____

Date of Birth: _____/_____/_____ Date of Injury: _____/_____/_____

Auto/PIP Insurance Company: _____

Insurance Address: _____

Insurance Phone Number: _____

Policy Number: _____ Claim Number: _____

Policy Holder/Insured: _____

Health Insurance Company: _____

Insurance Address: _____

Insurance Phone Number: _____

Policy Number: _____ Group Number: _____

Policy Holder/Insured: _____

Attorney Name: _____

Attorney Phone Number: _____

By signing below, I acknowledge that the information provided is correct and that there is no other insurance in effect at this time. I agree to pay all charges not covered by the above-listed insurance company(s).

Signature: _____ Date: _____/_____/_____