ROBERT S. PATITUCCI, M.D
MOTOR VEHCLE/WORKMENS COMPENSATION CLAIMS

TO THE PATIENT:
In order for us to file a claim on your behalf you must provide us with the information we need to process your claim quickly and efficiently. Please answer all appropriate areas of this form. If you should need any assistance, please as one of the office staff for help.

MOTOR VEHICLE CLAIMS

NAME OF PATIENT:_____DATE OF ACCIDENT:_____

CLAIM NUMBER: (THIS IS NOT YOUR POLICY NUMBER)_____

POLICY NUMBER: _____
NAME AND ADDRESS OF MOTOR VEHICLE INSURANCE:
(THIS IS THE ADDRESS WHERE WE SHOULD SEND MEDICAL CLAIMS)

_____

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_____

PHONE NUMBER OF AUTO INSURANCE: _____

ADJUSTERS NAME:_____ADJUSTERS PHONE:_____

WORKMEN'S COMPENSATION CLAIMS

NAME OF PATIENT:_____DATE OF ACCIDENT:_____

CLAIM NUMBER:_____

EMPLOYERS NAME:_____EMPLOYERS PHONE:_____
NAME AND ADDRESS OF WORKMEN'S COMPENSATION CARRIER:
(THIS IS THE ADDRESS WHERE WE SHOULD SEND MEDICAL CLAIMS)

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CONTACT PERSON AND PHONE NUMBER:_____

RELEASE OF INFORMATION:
Robert S. Patitucci, M.D. may disclose any or all parts of the clinical record to my insurance company and/or employer for purposes of satisfying charges billed by
Robert S. Patitucci, M.D..
ASSIGNMENT OF MEDICAL BENEFITS:
I herby authorize payment of medical benefits to Robert S. Patitucci, M.D. for any medical care rendered to me or my dependents. I understand that I am responsible for any amount not paid by my insurance and/or employer:

Signature:_____**Date:**_____