DETAIL REPORT

Most insurance companies require that the following information be completed and signed by you to process your claim.

PATIENT NAME: _____

INSURANCE CARRIER: _____

PATIENT ID NUMBER: _____

PLEASE CHECK APPROPRIATE BOX:

☞ ☐ INJURY - Date of Injury

☞ ☐ NOT RELATED TO AN INJURY

PLEASE GIVE DETAILED DESCRIPTION OF INJURY OR COMPLAINT–LISTING: WHEN, WHERE & HOW INJURED

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ARE THERE OTHER RESPONSIBLE PARTIES: _____

IF SO, NAME AND ADDRESS: _____

_____

_____

PATIENT/GUARANTOR SIGNATURE

_____

DATE

WHITE COPY - Office YELLOW COPY - Hospital/Insurance Copy