east lincoln family health professionals, pc

4525 S 86th Street, Ste. B Lincoln, NE 68526-9227
Telephone: 402-483-7507 Fax: 402-483-6899

Motor Vehicle / Third Party Form

Patient Name: ____ Date of Birth: _________________________

Parent/Legal Guardian Name (if minor): ____

Address: ____ Phone: ________________________

____

Today's Date: _________________ Date of Accident: _________________

Claim No.___________________

Agent or contact who is handling claims: ______________________________ Phone: _______________________

Insurance Name/ ____ Phone: _______________________
Where to Send Claims

Address: ______________________________________

____

Including Date of Injury, give a brief description of what occurred:

____
____
____
____
____
____
____

I authorize the release of any medical information necessary to process any MVA/Third-party claims. I understand that ALL information needs to be completed on this form for the office to submit my claim. We do require MVA and Third-Party visits to be paid at the time of the service. As a courtesy, we will submit the claim to the insurance carrier provided on the form. It is your responsibility to seek reimbursement from them. If we should receive payment from the insurance, your account will be issued a credit.

____ _______________________

Signature of Patient/Parent/Legal Guardian *Date*