

# AUTOMOBILE ACCIDENT INSURANCE QUESTIONNAIRE

Must be completely filled out in order to process claims

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Date of accident: \_\_\_\_\_ Claim #: \_\_\_\_\_

Auto Insurance Carrier \_\_\_\_\_

Claim Submission Address \_\_\_\_\_

\_\_\_\_\_

Agent's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you are also covered by a medical insurance policy, what insurance is primary for services related to your automobile accident?

Medical

Auto

I authorize the release of any medical information necessary to process this claim.  
I permit a copy of this authorization to be used in place of the original.

I hereby authorize Macomb Physicians Group, PLLC. to submit claims on my behalf for services rendered.

I authorize that payments from my insurance company be made directly to Macomb Physicians Group, PLLC.

I certify that the information I have provided is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_