LIABILITY CLAIMS (AUTO OR ACCIDENT INFORMATION)

Patient Name _____ Account No. _____

Type and date of injury: _____

Location/address of accident: _____

Have you reported this to an Insurance Company? ☐ No ☐ Yes If yes, whom? _____

Patient's Health Insurance: _____

Complete this section only for property accidents (non-motor vehicle):
Insurance Carrier for the property where accident occurred: _____
Claim Filing Address: _____
Claim Adjuster Name & Phone Number: _____
Claim Number: _____
What were you doing at this time? _____

Complete this section only for motor vehicle accidents:
Patient's Auto Insurance Carrier: _____
Claim Filing Address: _____
Claim Adjuster Name & Phone Number: _____
Claim Number: _____
Other Vehicle Auto Insurance Carrier: _____
Claim Filing Address: _____
Claim Adjuster Name & Phone Number: _____
Claim Number: _____ Driver/Insured's Name: _____

Was an accident report filed? ☐ No ☐ Yes If yes, where? _____
(Please attach a copy of the report if the accident occurred outside Lincoln, Nebraska)

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other: _____

Have you retained an attorney regarding this accident? ☐ No ☐ Yes If yes, Attorney Name, Phone, Address:

_____

I agree that if the above insurance denies any services, I receive from Nebraska Orthopaedic Center that I am personally and fully responsible for payment for any charges incurred. I understand I will receive statements until the liability carrier has processed the claims for those services. I hereby authorize the release of any medical information necessary to process my liability insurance and request payment of benefits to the provider or services. I understand I can also visit www.nebraskaortho.com to learn more about liability claims policies.

_____ _____
Date Patient Printed Name

_____
Patient Signature*
*Parent/Guardian Signature if patient is a minor