MEDINA FAMILY MEDICAL CLINIC
MOTOR VEHICLE CLAIMS

This information is necessary for claims you would like submitted to an auto insurance carrier. Please contact your auto insurance carrier to report the accident and get the following information so that we can file your auto insurance carrier for payment on your medical claim.

For your convenience, this form can be given to us by:
Fax: (731) 783-0402
Mail: PO Box 100
Medina TN 38355

Patient Name: ______________________________

Account Number: ______________________________

Insurance Name: ______________________________

Insurance Address: ______________________________

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Address where claims are to be sent: ______________________________

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Policy Number: ______________________________

Claim Number: ______________________________

Insurance Phone Number ______________________________

Adjuster / Contact Person: ______________________________

Original Date of Accident: ______________________________

This information is necessary, before we can file your claim. If we are unable to verify this information, you will be required to pay for your visit and services provided.