AutoVerification Form

Date:________________ Dr:____

Patient in office:_____________________ Date/Time of Appointment:_____________________________________

Doctor’ s Office Completes

Patient:____Date of Birth:___________________________

SS#: ____Policy #: ____

Chief Complaint:____

Accident: (Include body areas affected, speed, position, detailed description of incident): ___________________________

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Date of Injury:____

Agents Name: ____

Agents Phone Number: ____

Major Medical Carrier: _______________________________________Phone Number: _________________________

Insured Name: ___________________________________ Insureds ID #: ______________________________________

Group Number: ____ Plan: ___________________________________

Practical Management Completes

PIP Benefits ____ Yes ____ No Med Pay ____ Yes ____ No Uninsured/Underinsured ____ Yes _____ No

Insurance Company: ____

Claims Address:____

City,St.Zip: ____

Phone Number: ______________________________________ Fax Number: __________________________________

Claim Number: ____

Application for Benefits sent to patient: ____ Yes Date:____________ No ______ When Expected Date: ____________

Insurance Representative/Adjuster:____

Major Medical Carrier: _______________________________________Phone Number: _________________________

Insured Name: ___________________________________ Insureds ID #: ______________________________________

Group Number: ____ Plan: ___________________________________

PM Staff member:____

Practical Management
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