MVA INFORMATION FORM

Please complete the form in its entirety. Failure to do so will result in the bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Patient Name: ____D.O.B:____________________

Home Phone: ____Work Phone: _____________________________

Auto Insurance Company Name: ________________________Auto Ins Company Phone:____________________

Auto Insurance Company Billing Address: ____

Name of Auto Insurance Policy Holder: ____

Accident Claim Number: ____

Adjusters First and Last Name: ____

Adjusters Phone Number: ____

Insurance Authorization # for treatment: ____

Date of Accident :_______________________________ Time of Accident: ______________________________

Date Authorization Obtained: ____________________ State the accident took place: ______________________

Were you a pedestrian, passenger or the driver of the vehicle:____

Were you utilizing public transportation during the accident: Yes / No
Is there an existing open claim: Yes / No
Have you submitted the police report to your insurance company: Yes / No
Have you completed your PIP application: Yes / No

I _________________________agree to pay for services provided at High Mountain Health if payment is denied for any reason. I authorize High Mountain Health to submit claims on my behalf to the Auto Insurance listed above.

Patient/Guardian Signature: ____Date: _______________

Wayne – Urgent Care
246 Hamburg Tpk
Ph: 973.389.1800
Fax: 973.636.2734

Wayne
468 Parish Drive
Ph: 973.305.8300
Fax: 973.305.8157

Waldwick – Urgent Care
71 Crescent Ave
Ph: 201.445.1700
Fax: 201.445.1701

Billing Department
401 Hamburg Tnk
Ph: 973.890.2780
Fax: 973.890.8960

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www.HighmountainHealth.com