JERSEY REHAB, P.A., P.C.

Physical Medicine & Rehabilitation – Electrodiagnostic Medicine
Subspecialty, Pain Management
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ACCIDENT INSURANCE INFORMATION

TYPE OF ACCIDENT: MOTOR VEHICLE _____ WORKMEN'S COMPENSATION _____ LIABILITY _____
DATE OF ACCIDENT: _____ DO YOU HAVE AUTO INSURANCE? YES / NO
NAME OF INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
POLICY #: _____ CLAIM #: _____
CLAIM REPRESENTATIVE: _____
WERE YOU THE DRIVER? _____ PASSENGER? _____ PEDESTRIAN? _____ OTHER _____
BRIEF DESCRIPTION OF ACCIDENT _____
_____

HAS THIS ACCIDENT BEEN REPORTED TO YOUR INSURANCE COMPANY? YES / NO
IF NOT, YOU MUST REPORT THE ACCIDENT TO YOUR INSURANCE COMPANY TO PROTECT YOUR BENEFITS, EVEN IF YOU WERE NOT AT FAULT.

IF YOU WERE THE PASSENGER IN A VEHICLE NOT OWNED BY YOURSELF WE WILL NEED THE FOLLOWING INFORMATION:
VEHICLE OWNER: _____ INSURANCE COMPANY: _____
POLICY #: _____ CLAIM #: _____
DOES ANYONE ELSE IN YOUR HOUSEHOLD HAVE AUTO INSURANCE OF THEIR OWN? YES / NO
NAME: _____ RELATIONSHIP: _____
INSURANCE CO: _____ POLICY #: _____

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WORKMEN'S COMPENSATION INFORMATION: DATE OF ACCIDENT: _____
AUTHORIZED FOR TREATMENT: _____ UNAUTHORIZED FOR TREATMENT: _____
EMPLOYER'S NAME: _____
WORKMEN'S COMPENSATION CARRIER: _____
WORKMEN'S COMPENSATION CARRIER ADDRESS: _____
CITY _____ STATE _____ ZIP CODE _____ TEL # ( ) _____
CLAIM REPRESENTATIVE _____ OR CONTACT PERSON _____

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ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS INJURY? ( ) YES ( ) NO
ATTORNEY NAME: _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # ( ) _____ PARALEGAL OR SECRETARY NAME _____