

# LIABILITY FORM

PATIENT NAME \_\_\_\_\_ SSN# \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ DATE OF SURGERY: \_\_\_\_\_

ACCIDENT RELATED? [ ] AUTO [ ] OTHER

STATE IN WHICH AUTO ACCIDENT OCCURRED? \_\_\_\_\_

## **LIABILITY INSURANCE COMPANY INFORMATION**

LIABILITY INSURANCE CARRIER: \_\_\_\_\_

CLAIM # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

AGENT/ADJUSTER'S NAME \_\_\_\_\_

PHONE \_\_\_\_\_

FAX \_\_\_\_\_

WAS A POLICE REPORT FILED? [ ] YES [ ] NO

WHO'S FAULT WAS THE ACCIDENT? \_\_\_\_\_

ATTORNEY'S NAME \_\_\_\_\_

FOR OFFICE USE ONLY:

**AUTHORIZATION FOR PROCEDURES**

**DATE /APPROVED BY**

_____	_____
_____	_____
_____	_____
_____	_____