39 CARL   DRIVE
NORTHAMPTON MA 01060 p (413) 727-3315 f (413) 727-3816
SYNERGYPT413@GMAIL.COM

MOTOR VEHICLE ACCIDENT

Patient Name: ______________________ Date of Service ______________________

Subscriber's Name: ______________________

Insurance Carrier: ______________________ Phone :______________________

Address: ______________________ Fax : ______________________

____

Type of Injury: ______________________

Date of Injury: ______________________

Should this visit be paid as a Motor Vehicle Accident claim? ☐ Yes ☐No

Please send bill to insurer named above for payment ☐ Yes ☐ No

Please send bill to patient's insurance company : Name of Subscriber:______________________

Carrier Name: ______________________

Address: ______________________

Claim No. ______________________Attention:______________________

Phone: ______________________ Fax: ______________________

Adjustor: ______________________

This form must be completed and returned to us. If we do not receive a response, the patient will be billed directly for payment of the services rendered.

Although a third party carrier may be billed for payment of the services rendered, by verifying the above as a motor vehicle claim **the above patient understands that they are ultimately responsible for payment of the services rendered** and that their insurer will receive directly all billings and correspondence.

Questions? Please call us at (413) 727-3315

PLEASE FAX COMPLETED & SIGNED FORM TO (413) 727-3316