

YOUR Auto Insurance Company	
Name on Policy	
CLAIM # Assigned to case	
DATE Claim Assigned	
Claims Adjustor Assigned	
Claims Adjustor's Phone	
Claims Billing Address	
Med Pay Coverage	_____Yes _____No
Other Party's Insurance Company	
Name on Policy	
Name of Driver	
Claim # Assigned	
Date Claim Assigned	
Claims Adjustor Assigned	
Claims Adjustor's Phone	
Claims Billing Address	
Name of Your Attorney	
Phone Number	
Address	

******PLEASE BE ADVISED:** As stated in our payment agreement, our office policy is to bill YOUR auto insurance med-pay regardless of accident fault. Your insurance will pay your bills as they incur. The responsible at-fault insurance company should reimburse your insurance company at the time of settlement. It is your responsibility to set up a med-pay claim with your auto insurance company.

Signature _____ Date _____