MOTER VEHICLE ACCIDENT (MVA) INSURANCE FORM

Hudson's Bay Medical Group will be glad to bill *YOUR PERSONAL* motor vehicle insurance provided you supply the following information.

_____, _____

PRINT NAME DATE OF BIRTH

MVA INSURANCE NAME: _____

BILLING ADDRESS FOR MEDICAL CLAIMS: _____

_____

_____

CLAIM NUMBER: _____

DATE OF ACCIDENT: _____

STATE WHERE ACCIDENT TOOK PLACE: _____

CLAIM ADJUSTER'S NAME: _____

CLAIM ADJUSTER'S PHONE NUMBER: _____

Do you have Personal Injury Protection (PIP) coverage on your motor vehicle insurance? Circle one: YES/ NO

Please indicate to the front desk every time you come in for an office visit related to this MVA policy. It is your responsibility as the patient to see that Hudson's Bay Medical Group receives payment from your motor vehicle insurance company in a timely manner. After 90 days, if your motor vehicle insurance company has not paid your bill, it becomes your responsibility.

Please also provide your personal medical health insurance information (this is in case you have non-MVA related medical treatment). If you have neither PIP nor personal medical health insurance, we will require payment in full at time of service.

I understand that each time I am seen regarding my MVA a copy of my office visit and any related testing will be sent to the above listed insurance company. This release is to remain in place until my claim has been closed.

_____, _____

PATIENT SIGNATURE DATE

Hudson's Bay Medical Group Inc. P.S.

MOTER VEHICLE ACCIDENT (MVA) QUESTIONNAIRE

_____, _____

PRINT NAME DATE OF BIRTH

When were you involved in the motor vehicle accident?

Date: _____ Time of Day: _____ AM/PM

1. Where did the accident take place? _____
2. Were you driving the vehicle? YES / NO
3. Where were you seated in the vehicle? _____
4. What is the type, make and year of vehicle? _____
5. What size was the vehicle? SMALL/ MEDIUM/ LARGE
6. Were you wearing your seatbelt? YES/ NO Did it have a shoulder harness? YES/ NO
7. Did your seat have a headrest? YES/ NO
8. What was the type, make and year of the other vehicle involved in the MVA? _____
   _____
9. Describe the accident: How did it occur (rear-ended etc.). _____
   _____
   _____
   _____
10. What was your estimated speed at the time of the accident? _____ M.P.H.
11. What was the estimated speed of the other vehicle at the time of the accident? _____ M.P.H.
12. How much damage was there to your vehicle? _____
13. Was anyone else in your vehicle injured? YES/ NO
14. Did you have any immediate pain at the time of the accident? YES/ NO
15. Did you have any head injuries or lose of consciousness (get “knocked out”)? YES/ NO
16. Have you already been seen elsewhere for this accident? If so, where? _____
17. Have you already had x-rays taken for this accident? If so, where? _____
18. Did you have any pain hours after the accident? Where? _____
    _____
19. Do you currently have any pain? If so, where? _____
20. Are your injuries getting better or worse since the accident? _____
21. Have you previously injured any of these areas? _____
22. Have you taken any medication for your injuries? _____
23. Additional comments: _____
    _____
    _____

_____, _____

PATIENT SIGNATURE DATE