LEHIGH VALLEY FAMILY PRACTICE
1401 Fairmont Street
Whitehall, PA 18052
Phone: (610) 432-4122 Fax: (610) 432-6677

INJURY/ACCIDENT DETAILS AND CLAIM INFO

Patient: ______________________________ DOB: ____________ Sex: M__ F__

Date of Injury/Accident: ________________ Time of Injury/Accident: ______________

Location where the injury/accident occurred: (circle one) **PA NJ NY DE CT Other** _________

How did the injury/accident occur: ____

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Who did you report your injury/accident to: ___________________________________

____

Insurance Name: ____

Claims P.O. Box address: ____

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Claim number: ____

Claims Adjuster Name and Phone number: ____________________________________

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Have benefits been exhausted? (for MVA only) **NO YES** if yes, please provide primary health insurance info and copy of insurance card to the front desk.

Health Insurance Name: ____

Address: ____

ID#: ___________________________________ Group #: ____________________