LSM Chiropractic
www.lsmchiro.com
Providing quality care since 1954

forward NATURAL MEDICINE
www.forwardnaturalmed.com

PATIENT PERSONAL INJURY REPORT FOR MVA

LSM/FNM will file your claims to your auto policy first if medical payment is available regardless of who is at fault. If medical payment is not available on your auto policy, claims will be filed to the at fault party's auto insurance in which you are responsible for claim payment upon settlement without reduction of fees. Should you retain an attorney who advises otherwise, LSM-FNM will pursue processes under your attorney's advisement. Should no other benefits be available, health insurance may be billed in which all deductible, copays and non-covered items are payable by the patient within 30 days of processing. LSM-FNM reserves the right to deny deferment of payment for personal injuries.

TODAY'S DATE*:

INJURY DATE*:

PATIENT AT FAULT* (*CIRCLE ONE*) Y / N

*** - Indicates required field to be completed by patient**

PATIENT NAME*
PATIENT HEALTH INSURANCE (If Dean, Bill Primary)*
PATIENT'S AUTO INSURANCE COMPANY*
PATIENT'S AUTO POLICY NUMBER*
PATIENT'S AUTO INSURANCE PHONE NUMBER
PATIENT HAS MEDPAY AVAILABLE (CIRCLE ONE) Y / N
PATIENT'S MEDPAY CLAIM NUMBER*
PATIENT'S AUTO POLICY MEDPAY ADJUSTER NAME
PATIENT'S AUTO POLICY MEDPAY ADJUSTER PHONE
PATIENT'S MEDPAY LIMIT
PATIENT'S AUTO CLAIM MAILING ADDRESS

**** - Indicates required fields to be complete by patient if there is an additional at fault party**

AT FAULT PARTY'S NAME**
AT FAULT PARTY'S AUTO INSURANCE**
AT FAULT PARTY'S AUTO INSURANCE POLICY NUMBER**
AT FAULT PARTY'S AUTO INSURANCE PHONE NUMBER **
IS THERE A BODILY INJURY CLAIM OPEN (CIRCLE ONE) Y / N
BODILY INJURY CLAIM NUMBER
ADJUSTER NAME
ADJUSTER PHONE NUMBER
CLAIM MAILING ADDRESS
ADJUSTER EMAIL

HAS AN ATTORNEY BEEN RETAINED*: Y / N
If yes, complete PAGE 2 with Attorney Information

I UNDERSTAND THAT I AM RESPONSIBLE TO ENSURE ALL CHARGES ARE PAID IN FULL.

PATIENT SIGNATURE: _____ DATE: _____

INTERNAL USE ONLY:
LIEN DATE: _____
CLAIM INFORMATION WAS VERIFIED BY: _____ ON: _____