

Date _____
Account # _____
Physician _____

Midwest Orthopaedic INSTITUTE

Liability Claim Information

Patient Name: _____

Date of Birth _____ Social Security Number _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Liability Carrier _____

(Insurance Company)

Insured Person _____ Phone Number _____

Billing Address _____

City/State/Zip _____

Contact Person _____ Phone Number _____

Send Insurance Claim to: _____ Carrier (Insurance) _____ Patient

Claim Number _____

Type of Injury _____

Date of Injury _____

I understand that I am fully responsible for payment of the charges related to my visit to the physician. If the liability carrier listed above denies payment for whatever reason, I understand that I will receive a bill for the services rendered and it will be my responsibility to pay the bill.

Patient Signature _____ Date _____