



**ABOUT YOUR INSURANCE**

**We will need a copy of all insurance cards**

**We will submit your insurance. You remain responsible for all charges**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: ( if applicable): \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

If Medicaid, Passport Provider: \_\_\_\_\_

WORKERS COMPENSATION INJURY? \_\_\_ YES \_\_\_ NO Date of Injury: \_\_\_\_\_

AUTO ACCIDENT? \_\_\_ YES \_\_\_ NO Date of Injury: \_\_\_\_\_

**IF YOU ANSWERED "YES" TO EITHER WORK COMP OR AUTO ACCIDENT- PLEASE COMPLETE THE INFORMATION BELOW FOR OTHER REQUIRED INFORMATION NEEDED TO PROCESS YOUR CLAIM.**

**WORKERS COMPENSATION**

EMPLOYER AT TIME OF INJURY: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS \_\_\_\_\_

*STREET ADDRESS CITY STATE ZIP*

SUPERVISOR \_\_\_\_\_ PART OF BODY INJURED \_\_\_\_\_ L \_\_\_ R \_\_\_

DATE OF INJURY: \_\_\_\_\_ LAST WORKED DATE: \_\_\_\_\_

WORK COMP INSURANCE CARRIER: \_\_\_\_\_

WORK COMP CARRIER ADDRESS: \_\_\_\_\_

*STREET ADDRESS CITY STATE ZIP*

CLAIMS EXAMINER: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

**AUTO ACCIDENT**

POLICY HOLDER: \_\_\_\_\_

CLAIM #: \_\_\_\_\_ ACCIDENT DATE: \_\_\_\_\_

INSURANCE AGENCY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

*STREET ADDRESS CITY STATE ZIP*

AGENT: \_\_\_\_\_ PHONE#: \_\_\_\_\_

**THIS INFORMATION MUST BE COMPLETED IN ORDER FOR HIMPT TO BILL FOR SERVICES. IF IT IS NOT COMPLETE, THE PATIENT WILL BE RESPONSIBLE FOR FULL PAYMENT AT THE TIME THEY ARE TREATED. PATIENT IS RESPONSIBLE FOR PAYMENT IN FULL OF ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. HIMPT2010**