CLAIM INFORMATION REPORT

ACCIDENT INJURIES: (circle one)	ACC MVA WCC DATE OF INJURY: ___________

PHYSICAL: (circle one)	Work Insurance Employer

PATIENT NAME: ____ DATE OF BIRTH: ____________________

ADDRESS: ____ PHONE: ___________________________

EMPLOYER: ____ KS OR MO? PHONE: ______________________

HOW WERE YOU INJURED?:____

WORKERS' COMPENSATION, INJURIES & PHYSICALS

COLLEGE PARK does not treat DEPTARMENT OF LABOR Workers' Compensation Claims

WHO IS TO RECEIVE THE CLAIM? (CIRCLE ONE) EMPLOYER / WORK COMP INSURANCE / OTHER COMPANY

INSURANCE/COMPANY NAME: ____ CLAIM #: __________________

CLAIMS MAILING ADDRESS: ____

ADJUSTOR: ______________________________________ PHONE: ____________________________________

INJURY REPORTED TO: ____________________________________ DATE: ______________________________

*****MISSOURI EMPLOYEES MUST HAVE THE ACCIDENT VERIFIED PRIOR TO BEING SEEN BY PROVIDER*****

MOTOR VEHICLE

Please check the box that applies to the motor vehicle accident and complete insurance information.

CLAIM TO BE FILED TO PATIENT'S AUTO INSURANCE	**CLAIM TO BE FILED TO PATIENT'S HEALTH INSURANCE**
☐ KS Resident	☐ MO Resident/MO Accident
☐ MO Resident/KS Accident	☐ NO Auto Insurance

■ **If KS Resident & PIP is exhausted, please provide BOTH Auto and Health insurance information.**

Auto	Health
Auto Carrier	Health Insurance Carrier
Claims Mailing Address	Claims Mailing Address
Policy # / Claim#	Policy #
Adjustor	Group #
Phone Number	Phone Number

I hereby authorize College Park Family Care Center (CPFCC) to submit claims to the above named insurance or company for all services rendered regarding the accident injury listed above. I hereby authorize CPFCC to release information regarding the accident injury listed above to obtain payment for services provided. In the event the insurance or company does not pay, I assume responsibility and will pay the balance in full.

Patient Signature: ____ Date: _____________________

- ⇨ **If KS resident; claim(s) filed to personal auto insurance, not to at-fault driver.**
- ⇨ **If MO resident; KS accident: claim(s) filed to personal auto insurance, not to at-fault driver.**
- ⇨ **If MO resident; MO accident: claim(s) filed to health insurance only.**
- ⇨ **If Department of Labor; Work Comp Injury: CPFCC does not treat or file Dept. of Labor Work Comp.**

To Be Completed by CPFCC Staff:

Claim form taken by: ____ Date: ____________________

RE: WCC VERIFICATION: (the following info from employer)

Verified by: ____ Position w/Co: _______________________

CPFCC Employee who verified: ____________________________________ Date: ____________________

****ATTACH Physical form if applicable.*

FAX TO TERRIE @ 913-428-1512

Updated 10/10/12