



**MIDDLETON**

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**Motor Vehicle information (MVA)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of accident: \_\_\_\_\_

Body Part(s) Injured: \_\_\_\_\_

MVA Insurance: \_\_\_\_\_

MVA Claim Address: \_\_\_\_\_  
\_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjustor: \_\_\_\_\_ Adjustor Phone \_\_\_\_\_

**If you are the subscriber list as self**

Health Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group No.: \_\_\_\_\_

**Please read**

I authorize the assignment of all medical payments from all insurance(s) listed above for office visits/procedures related to this accident/injury sent directly to Middleton Family Medicine Urgent Care. In the event that MVA insurance does not approve claims I assume full financial responsibility. If I have Medical Health insurance it is my responsibility to inform the billing department at Middleton Family Medicine within 90 days of the date of service that is denied along with any letters from MVA stating why they are denying the claim. If both parties deny a claim it is my responsibility to resolve this matter by contacting them. I become financially responsible for all balances due.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_