

FRANKFORD AVENUE FAMILY PRACTICE
A DIVISION OF
PINNACLE PHYSICIANS GROUP, LLC
8846 FRANKFORD AVENUE
PHILADLEPHIA, PA 19136
215-332-8221
215-332-2979

WORKMAN COMP / AUTO ACCIDENT

NAME: _____

D.O.B.: _____

DATE OF INJURY/ACCIDENT: _____

CLAIM NUMBER: _____

NAME & MEDICAL BILLING ADDRESS OF INSURANCE COMPANY:

TELEPHONE # OF INSURANCE COMPANY: _____

PERSON HANDLING CLAIM: _____

PHONE NUMBER + EXTENTION: _____

STATE IN WHICH ACCIDENT OCCURRED: _____

PERSONAL MEDICAL INSURANCE + ID NUMBER: _____

IN THE EVENT MY INSURANCE WILL NOT COVER THE CLAIM, I REALIZE THAT I
AM RESPONSIBLE FOR THE PAYMENT IF I HAVE NO OTHER COVERAGE.

SIGNATURE: _____ DATE: _____
