BROCKTON PEDIATRICS, INC
65 LIBBY STREET
BROCKTON, MA 02302
508-584-6060

***PLEASE FAX INFORMATION TO 508-584-4949 ATT: ABBY

AUTOMOBILE BILLING REQUIREMENT

NAME OF PATIENT: ____

DOB: ______________________ DATE OF ACCIDENT: ________________

INSURANCE CARRIER: ____

ADJUSTER'S NAME:____

ADJUSTER'S PHONE W/ EXT: ____________________________________

CLAIM#: ____

INSURED NAME: ____

ATTORNEY NAME- ADDRESS- PHONE: (if applicable)

____

(   ) During this visit **I DID NOT** have any information regarding this accident. I understand Brockton Pediatrics will bill my health insurance if they DENY payment, I am responsible for FULL payment on any charges incurred.

MVA WAIVER

My son/daughter ________________________________ is seeking treatment for the following symptoms _____________________ on this date ______________. The above symptoms were caused by MVA injury sustained on _____________.

Please initial the following statements:

(   )I authorize Brockton Pediatrics to bill the Auto insurance given by me on this date.

(   )I understand that if the auto insurance does not cover this visit, Brockton Pediatrics will bill my health insurance carrier.

(   )I understand that if my health insurance carrier denies any payment, charges incurred will be my sole responsibility.

(   )Any copayment from my health insurance carrier will be billed to me and it is my responsibility to make this payment as soon as possible.

Guarantor Name: ____ (print)

Signature: ____

Date: ____