Paul H. Deutsch M.D., R.Ph., LLC
86 New London Turnpike Norwich, CT 06360
Phone: 860 889-6967 Fax: 860 885-1033

AUTO ACCIDENT FORM

Name ____

D.O.B. ____

Address ____

City/Town ______________________________________

Zip Code_____________ Tel. #______________________

PERSONAL INSURANCE INFORMATION

Primary Insurance ________________________________

Subscriber Name _________________________________

D.O.B. ____

Relationship to Subscriber ________________________

ID# ____

INJURY

Date of Injury____________________________________

City/Town of Injury_______________________________

State _____________ Zip Code______________________

Body Part(s) _____________________________________

Cause of Injury___________________________________

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Reported to Auto Insurance YES ☐ NO ☐

Med Pay Letter YES ☐ NO ☐

If your personal Insurance is being billed, you must obtain a no med pay letter from you Auto Insurance Carrier.

INSURER

Auto Insurance Carrier

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Address ____

City/Town _______________State_______________

Zip Code _______________________________________

Claim Number ___________________________________

Claim Representative ______________________________

Tel. #____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

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PATIENT SIGNATURE

I authorize _____________________ to assign benefits to the following provider service:

Name: **Dr. Paul H Deutsch, MD, RPH., LLC**

Address: **86 New London Turnpike**

City, State & Zip Code: **Norwich, CT 06360**

I understand that the charges listed may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the above provider for the cost of treatment.

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PATIENT SIGNATURE

Revised 1/23/14