PULMONARY AND MEDICINE ASSOCIATES

27472 **Schoenherr Rd. Suite 100 Warren MI 48088**
Phone (586) 751-8844 Fax (586) 751-8596

WORKER'S COMP ACCIDENT INSURANCE QUESTIONARE

Must be completely filled out in order to process claims

Patients Name:_____

Address: _____

_____

Phone Number: _____

Date of Accident: _____

Claim Number: _____

Description of Injury: _____

Insurance Carrier: _____

Claim Submission Address: _____

Employer: _____

I authorize the release of any medical information necessary to process this claim.

I permit a copy of this authorization to be used in place of the original.

I hereby authorize Pulmonary and Medicine Associates, PLLC to submit claims on my behalf for services rendered.

I authorize that those payments from my insurance company be made directly to Pulmonary and Medicine Associates, PLLC.

I certify that the information I have provided is correct.

Signature: _____ Date: _____