

Fax

To:	MRA	From:	
Fax:	(615) 963-3849	Pages:	1 (including cover)
Re:	Premises Inquiry Premises: Patient: ROBERT W GILLILAND MRA #(s): 5089896	Date:	

☒ There was no accident reported or claim filed with our premises liability carrier.

☐ The accident was reported and a claim was filed with the carrier listed below:

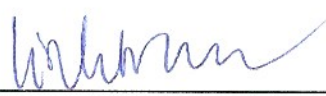
Insurance Company: _____

Telephone: _____

Policy or Claim #: _____

☐ Our premises liability policy has no medical payment benefit provisions.

Insurance Policy Date Range: From _____ To _____

Signed by: 

Date: _____

Print Name: THUY LINH TRAN

PLEASE FAX THIS STATUS UPON COMPLETION TO (615) 963-3849 . THANK YOU FOR YOUR COOPERATION IN THIS MATTER.