VIRGINIA GATEWAY URGENT CARE CENTER

Motor Vehicle Accident Information

Patient Name:_____ Date:_____

Date of Accident:_____

Reason for Visit:_____

Insured's Name:_____

Relationship to Insured:_____

Patient was _____Driver _____Passenger

Insurance Company:_____

Insurance Agent:_____ Phone No._____

Claim No.:_____ Policy No.:_____

Adjuster's Name:_____ Phone No._____

Adjuster Fax Number:_____

Name of Person Confirming Med Pay Coverage:_____

Billing Address:_____

_____

REV 11/15