Maryland Primary Care Physicians, LLC
P.O. Box 1590
Millersville, MD 21108
410-729-2642 443-679-1386 (fax)

MOTOR VEHICLE ACCIDENT FORM

MPCP Account # ________________________

Patient Name: ____

DOB: ______________________ SSN: ______________________

Claim Adjustor's Name:______________________ Claim Adjustor's Phone #: __________________

PIP Claim Address:____

PIP Claim #: ____

Car Insurance Company: ____

(Please note that this is for the automobile you were in at the time of the accident.)

Driver of Vehicle ______________________ Date of Accident ______________________

Phone #: ______________________ Policy #: ______________________

Name of Policyholder: ____

Attorney Name: ______________________ Phone #: ______________________

Attorney Address: ____

Patient Health Insurance Name: ____

ID#: ______________________ Group#: ______________________

Patient Health Insurance Claims Address: ____

I, ______________________, hereby authorize Maryland Primary Care Physicians, LLC to apply for benefits on my behalf. I request that payment be made directly to Maryland Primary Care Physicians, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original.

I understand that if my insurance is not effective at the time of this visit, I will be responsible for the balance due for services rendered. I agree to pay for any services not covered by my insurance.

This authorization may be revoked by me, at any time, in writing.

____ ______________________

Signature Date