Medical Account Management, Inc.

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RE:
Patient Name:
Account Number:
Date of Service:
Amount Due:

INSURANCE INFORMATION

Were you injured on the job? If YES, who is your employer: _____
If NO, was this related to an automobile accident? Y☐/ N☐

Briefly describe how this injury occurred: _____

_____

Please identify the name of the **workers compensation** or **automobile insurance** carrier in the spaces provided below:

Insurance Name	Insurance Adjuster/ Agent
Insurance Address	Date of Accident/ Injury
Insurance Phone Number	Claims Adjuster
Policy Number/ Claim Number	Accident Report Number/ Case Number
Attorney's Name	Attorney's Address