Steven Wasserman, RN, DC
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PHONE VERIFICATION OF AUTO INSURANCE

DATE OF INJURY:_____

PATIENT:_____
INSURED:_____

YOUR INSURANCE CO:_____
INSURANCE PHONE #:_____
POLICY #:_____

MED PAY: ( ) YES ( ) NO
AMOUNT: $_____
HAS IT BEEN USED FOR THIS ACCIDENT? ( ) YES ( ) NO
HOW MUCH HAS BEEN USED? $_____
EXCESS MED PAY: ( ) YES ( ) NO

CLAIM #:_____

ADJUSTOR YOU SPOKE WITH: _____

ADDRESS CLAIMS MAILED TO :_____
_____
_____

COMMENTS: