Paul H. Deutsch M.D., R.Ph., LLC
86 New London Turnpike Norwich, CT 06360
Phone: 860 889-6967 Fax: 860 885-1033

AUTO ACCIDENT FORM

Name _____

D.O.B. _____

Address _____

City/Town _____

Zip Code_____ Tel. #_____

PERSONAL INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____

D.O.B. _____

ID# _____

INJURY

Date of Injury_____

City/Town of Injury_____

State _____ Zip Code_____

Body Part(s) _____

Cause of Injury_____

_____

Reported to Auto Insurance YES ☐ NO ☐

Med Pay Letter YES ☐ NO ☐

Your auto insurance will be billed first. You must obtain a no med pay letter from you Auto Insurance Carrier in order to bill your health insurance first.

INSURER

Auto Insurance Carrier

_____

Auto Insurance Claim Address

_____

City/Town _____State_____

Zip Code _____

Claim Number _____

Claim Representative _____

Tel. #_____

I authorize _____ to assign benefits to the following provider service:
(Auto Insurance Company)

Paul H Deutsch, MD, RPH., LLC
86 New London Turnpike
Norwich, CT 06360

I understand that the charges listed may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the above provider for the cost of treatment. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____

PATIENT SIGNATURE **DATE**

Revised 11/2024