Amherst Physical Therapy

282 Route 101, Unit 11, Amherst, NH 03031
Phone # 603-672-5125

Auto Carrier Information/Patient Responsibility

Patient Name: _____

You have indicated that you would like us to send the bills on your behalf to the auto insurance carrier through which you have a claim. We need specific information to bill on your behalf. If you have already provided us with the necessary information, we ask that you verify that this information is correct. If you have not provided us with this information, please fill in the information below.

Claim Number: _____

Date and State of Injury: _____

Auto Insurance Company: _____

Case Manager Name: _____ Phone: _____

Billing Address: _____

_____

Health Insurance Information:

Primary Insurance:		Insurance Identification Number:	
Policy Holder Name:	**Is policy holder a <u>RETIRED</u> Federal Employee?** ☐ **Yes** ☐ **No**	Sex: ☐ M ☐ F	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	

If med pay is exhausted or benefits are denied, we will bill your personal health insurance with your consent

<u>If we do not have the correct information, you may be held responsible for the total charges of services</u>

**We can only send bills to the insurance company that holds the policy to the car that you were in at the time of the accident; we can not send bills to the insurance company of the other party involved. [NH law states that the med pay checks be issued to the insured, not to the medical provider but as the patient you have a responsibility to pay the medical provider. We will charge a standard rate of $100 per visit and will expect the remaining balances be paid as the checks from the car insurance are issued to you.]

I have read the above statement and understand my financial responsibilities.

_____ _____

Signature **Date**