TRUNG HOA PHAM, MD, LLC
Diplomate of the American Board of Internal Medicine

MOTOR VEHICLE ACCIDENT (MVA) / WORKCOMP CASE
INCIDENT DETAILS AND LIABILITY CONSENT

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ Phone: _____

Incident type (Circle 1): MVA WORKCOMP OTHER (List Name): _____

Insurer Name: _____

Insurer Phone Number: _____ Insurer FAX Number: _____

Insurer Address: _____

Case/Claim / Policy Number: _____ Date of 1st Occurrence: _____

Adjuster Name: _____ Phone Number: _____

PATIENT'S INSURANCE AUTHORIZATION AND ACKNOWLEDGEMENT

I authorized TRUNG HOA PHAM, MD, LLC to apply for benefits on my behalf for services rendered by TRUNG HOA PHAM, MD, LLC. I request payment for my insurance company be made directly to TRUNG HOA PHAM, MD, LLC. I certify 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 claims. This authorization may be revoked by me at anytime in writing.

I understand that claim submitted to the above listed MVA or WorkComp insurance company is not a guarantee of payment. I understand that the submission to the MVA or WorkComp insurance company may exclude the opportunity for submitting claim to my health insurance company due to the time limit on claim submission. In such case, I will be responsible for the claim balance.

I understand that nothing herein relieve me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

Name: _____

Signature: _____ Date: _____