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_____ STATE MOTOR VEHICLE NO-FAULT INSURANCE INFORMATION

Please complete all the information – this information is vital to the processing of your no-fault claim

DATE: _____ **NAME: _____**

CARRIER: _____ DATE OF ACCIDENT: _____

TELEPHONE: _____ PLACE OF ACCIDENT: _____

POLICIHOLDER: _____ TIME OF ACCIDENT: _____

DATE OF BIRTH: _____ CLAIM NUMBER: _____

SSN: _____ CLAIM REP: _____

REFERRED BY: _____ TELEPHONE: _____

BRIEF DESCRIPTION OF ACCIDENT

_____

_____

DESCRIBE YOUR INJURY

_____

WERE YOU TAKEN TO THE ER (WHICH HOSPITAL): _____

HAVE YOU HAD X-RAYS: _____ MRI _____ CT _____ DATES: _____

DO YOU HAVE?

LOW BACK PAIN ____ LEG PAIN ____ NECK PAIN ____ ARM PAIN ____ NUMBNESS ____ WEAKNESS ____

HAVE YOU SEEN NEUROLOGIST? _____

HAVE YOU SEEN ORTHOPEDIST? _____

HAVE YOU TRIED PHYSICAL THERAPY? _____ TREATMENTS YOU'VE HAD: _____

LAST DATE OF EMPLOYMENT: _____ RETURN DATE: _____

The undersigned authorizes the release of any information relating to all claims for the benefits submitted on my behalf. I further acknowledge that my signature oh this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted.

_____ _____

(AUTHORIZED SIGNATURE) **(DATE)**