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Motor Vehicle Accident Waiver & Claim Information

Patient Name: _____ Date Of Birth: _____

Date Of Accident: _____

Claim Number: _____ Contact Person: _____

Insurance Company: _____ Phone Number: _____

Adjuster Name: _____

Mailing Address: _____

I authorize payment of medical benefits to BW Primary Care, LLC. for all services related to this worker's compensation claim.

If the claim has not been paid within 90 days from the date of service, you will be required to pay the balance in full.

Patient Signature: _____ Date: _____