MFM | HEALTH

Motor Vehicle Accident (MVA) Information Form and Financial Agreement

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Athena ID: _____

Date of Accident: _____ State Accident Occurred: _____

Body Part(s) Injured: _____

MVA Insurance Name: _____

_____

MVA Claim Address: _____

_____

Claim ID: _____

Adjustor Name: _____ Adjustor Phone #: _____

Adjustor Email Address: _____

Patient Authorization for Billing of Services and Financial Responsibility Agreement:

I authorize the assignment of all medical payments from all insurance(s) listed above for office visits or procedures related to this accident/injury sent directly to MFM Health. In the event my MVA insurance does not approve or cover services, I assume full financial responsibility. If I have Medical Health insurance, it is my responsibility to inform the billing department at MFM Health within 90 days of the date of service that is being denied along with any letters from MVA stating why they are denying the claim. If both parties deny a claim, it is my responsibility to resolve this matter by contacting them. I come financially responsible for all balances due.

My signature below indicates that I understand and agree to the statement above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____