

NAME (PLEASE PRINT)

OPC ACCOUNT NUMBER

O·P·C
ORTHOPAEDIC
PHYSICIANS OF
COLORADO, PC

AUTOMOBILE ACCIDENT FORM

PLEASE READ CAREFULLY

HAVE YOU ELECTED MEDICAL COVERAGE ON YOUR AUTOMOBILE INSURANCE?

YES _____ NO _____

IF YOU DO NOT KNOW PLEASE CALL YOUR AGENT NOW!!!!

You must notify your insurance agent of injury for this claim to be processed.

ALL INFORMATION BELOW MUST BE FILLED IN ACCURATELY. IF YOU ARE NOT ABSOLUTELY SURE ABOUT THE WAY TO ANSWER A QUESTION, PLEASE ASK SOMEONE AT THE DESK TO ALLOW YOU TO USE THE PHONE IN ORDER TO OBTAIN THE CORRECT INFORMATION.

Date of Accident: _____

Have you filed an accident report with your Insurance Company? _____

Name of Policy Holder

Phone Number of Policy Holder

Name of Insurance Company

Billing address for claims

City and State

Telephone Number

Claim #

Adjuster's Name

Agent's Name

Agent's Phone Number

I have read and completed all of the above information for filing my automobile accident claim.

I understand that my failure to report this accident to my agent makes me personally responsible for payment of all services rendered related to this accident/injury.

SIGNED

DATE