Jennifer M. Smith D.C.
1051 Town Center Dr.Orange City, FL 32763
Office: (386) 775-3600 • Fax: (386) 775-3602

AUTOMOBILE ACCIDENT HISTORY FORM

Full Name ______________________ Today's Date ______________

Address ______________________ City ______________ State ____ Zip ________

Home Phone ______________ Work Phone ______________ Occupation ______________

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age ________ Birthday ____/____/____

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ______________ SS# ______________

Referred By: Attorney ______________ Insurance ______________

Doctor ______________ Other ______________

HISTORY OF ACCIDENT (check all that apply)

1. Date of Accident ______________ Time of Accident ______________ Date of Exam ______________
2. Description of Accident ______________________________
____
____
____
3. Location of Accident Street ______________ City ______________ State ____
4. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other ______________
5. ☐ Traveling ☐ Stopped facing ☐ N ☐ S ☐ E ☐ W ☐ Unknown Direction
6. **YOUR** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
7. **OTHER** Vehicle Type(s): ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
8. Who was issued the citation? ☐ Nobody, we exchanged insurance info ☐ I was / My party ☐ Other party
9. ☐ Stopped and rear-ended ☐ Moving and rear-ended ☐ Slowing down to make stop / turn and rear-ended
   ☐ Head-on collision – other vehicle traveling in opposite direction ☐ Side swiped RIGHT / LEFT ☐ Rolled over
   ☐ Another vehicle ran stop sign / red light ☐ Lost control of vehicle ☐ Spun around ☐ T-boned RIGHT / LEFT
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle? ☐ Yes ☐ No
11. Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other ______________
12. Approximate speed of **YOUR** vehicle: ________mph
13. Approximate speed of **OTHER** vehicle: ________mph
14. Were you wearing a seat belt? ☐ Yes ☐ No Were you aware of the impending collision? ☐ Yes ☐ No
15. How far is the top of the headrest or seatback from the top of your head? (measurement in inches)
    ☐ 0" ☐ 1" ☐ 2" ☐ 3" ☐ 4" ☐ 5" ☐ 6" ☐ Other ________ ☐ Above ☐ Below
16. Did you strike any objects in the car? ☐ Yes ☐ No
17. If yes, then what? ☐ Steering column ☐ Rearview mirror ☐ Seat broke ☐ Dashboard
    ☐ Door frame ☐ Headrest ☐ Jarred or thrown about ☐ Windshield
    ☐ Cannot remember details (dazed) ☐ Other ______________
18. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees
    ☐ Shoulder ☐ Hip ☐ Other ______________

19. As a result of the accident were you? ☐ not injured ☐ cut/bleeding ☐ bruised ☐ dizzy ☐ nauseas
☐ blurred vision ☐ unconscious ☐ ringing/buzz in ears ☐ partially paralyzed ☐ other ______

20. If cut, bruised, and/or partially paralyzed please explain where ______

21. If you experienced immediate pain, please indicate where:

☐	Headache	☐ Left	☐ Right	☐	Neck pain	☐ Left	☐ Right
☐	Upper-back pain	☐ Left	☐ Right	☐	Mid-back pain	☐ Left	☐ Right
☐	Chest pain	☐ Left	☐ Right	☐	Low-back pain	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right
☐	Other ______						

22. After the accident, did you? ☐ go home ☐ go to work ☐ go about your business ☐ go to the hospital

HOSPITALIZATION

23. If taken to the hospital, how did you get there? ☐ Ambulance ☐ Driven by friend / relative ☐ Drove yourself ☐ Went later

24. If you went later, then when? ______ Name of hospital ______

25. Were you seen in the emergency room? ☐ Yes ☐ No

26. Were you admitted to the hospital? ☐ Yes ☐ No

27. If admitted, how long did you stay? ______

28. Name of admitting or hospital physician? ______

29. What was done in the emergency room or hospital? ☐ Examination ☐ Stitches ☐ X-rays ☐ Surgery
☐ Physical Therapy ☐ Casting ☐ Cervical collar ☐ Prescription(s) ______
☐ Other ______

30. After being released, what did you do? ☐ Return home to bed ☐ Return to work ☐ Return to the emergency room
☐ Other ______

31. When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days
☐ Did not consult one ☐ Other ______

(If patient consulted this office, skip to PAST HISTORY)

32. Who did you consult? Dr. ______ ☐ Family Physician ☐ Chiropractor ☐ Orthopedist
☐ Osteopath ☐ Neurologist ☐ Other ______

33. What did the doctor do? ☐ Chiropractic manipulation ☐ Examination ☐ X-rays ☐ Injections ☐ Traction
☐ Physiotherapy ☐ Prescription(s) ______ ☐ Other ______

34. How long were you under this doctor's care? ______

35. Are you still under this doctor's care? ☐ Yes ☐ No

36. Frequency or number of visits now? ______

37. Did the doctor refer you to or have you been to any other physician? ☐ Yes ☐ No
If yes, explain: ______

38. Were you sent for an independent medical examination? ☐ Yes ☐ No
If yes, to whom? ______

39. Other pertinent information ______

______

______

PAST HISTORY

40. Have you ever been in any previous accident of any kind? ☐ Yes ☐ No
    If yes, please give dates and details ____________________
    ____
    ____

41. Were you rendered permanently impaired? ☐ Yes what % ________ ☐ No

42. Has any other physician prior to this accident ever treated you for neck or back problems? ☐ Yes ☐ No
    If yes, please explain ____________________
    ____
    ____

43. Have you had any previous surgeries or any conditions that I should know about? ☐ Yes ☐ No
    If yes, please explain ____________________
    ____

44. Were you symptom free and in good health before this accident? ☐ Yes ☐ No
    If no, please explain ____________________
    ____
    ____
    ____

PRESENT COMPLAINTS

45. Please list your current problem areas (prioritize with worst being #1)
    1. ____________________
    2. ____________________
    3. ____________________
    4. ____________________
    5. ____________________
    6. ____________________
    7. ____________________
    8. ____________________

46. Have you lost any time from work since the accident? ☐ Yes ☐ No

47. If yes, how many days? ____________ Are you still off work? ☐ Yes ☐ No

48. Date returned ____________ Job description ____________

49. In what way have your injuries affected your ability to work? ____________________
    ____
    ____

50. Have your injuries affected your hobbies and/or recreational activities? ☐ Yes ☐ No

51. If yes, please explain. ____________________
    ____
    ____

49. If you have an attorney representing you, please give name, address, and telephone number:

Name ____________ Firm ____________

Address ____________ City ____________

State ______ Zip ____________ Phone ____________

REVISED 02-02

TERMS OF ACCEPTANCE AND CONSENT FOR TREATMENT

I, the undersigned patient, parent or legal guardian, know that I (the patient) am suffering from a condition requiring chiropractic care. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal. Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment. "Vertebral Subluxations" are mechanical interferences, by the spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of Chiropractic is to locate, analyze and correct these vertebral subluxations.

The method of correction is by specific adjustments of the spine and/or extremity joints. These adjustments are intended to reduce subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency. With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other the subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specialized in that area. Regardless of what the disease, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our method of treatment is the spinal or extremity adjustment of vertebral or extremity subluxations, as well as additional modalities required to facilitate this adjustment.

I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I acknowledge that closed rooms are available to me at any given time, but may result in longer wait times. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

I, ______________________________ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis ______________________________
(Signature) (Date)

Complete if Patient is a minor child.

____
(Print Child's Name)

I, ______________________________ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____
(Signature) (Date)

JENNIFER M. SMITH DC

NAME:____ **PATIENT #** ____________________

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.

2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

3. Method of payment you plan to use to take care of today's charges? □ Cash □Check □Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. Jennifer Smith will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Dr. Jennifer Smith will be credited to my account upon receipt. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize the office of Dr. Jennifer Smith to obtain a credit report if deemed necessary.

Patient's Signature ____ Date ______________

DIRECT PAYMENT AUTHORIZATION

I hereby instruct and direct payment to be made payable to and mailed directly to:

Health and Wellness Chiropractic Center
Dr. Jennifer M. Smith
1051 Town Center Drive
Orange City, FL 32763
(386)775-3600

In consideration of the services rendered I authorize and direct the payment to the above named of any sum I now or hereafter owe out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. The payment will not exceed my indebtedness to the above mentioned.

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize use of this form for all insurance claims.

Patient's Signature ____ Date ______________

X-RAY / MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to physicians, employers and/or insurance companies which would expedite the process of my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I have requested the release of records of (patient's name) ______________________________which are a part of the records at (facility) ____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all insurance information, copies of records and reports, including copies of x-rays, and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Patient's Signature ____ Date ______________

Guardian's Signature ____ Date ______________

Jennifer M. Smith, D.C.
1051 Town Center Drive, Orange City, FL 32763
Office: (386)775-3600 * Fax: (386)775-3602

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED INFORMATION

PATIENT NAME: ____________________________ DATE OF BIRTH:__________________

ADDRESS:__________________________________ CITY AND ZIP:____________________

TYPE OF PRIVATE HEALTH INFORMATION TO BE RESTRICTED OR LIMITED
(PLEASE CHECK ALL THAT APPLY)

- o HOME ADDRESS
- o HOME PHONE NUMBER
- o WORK PLACE
- o VISIT NOTES
- o PATIENT HISTORY
- o OFFICE ADDRESS
- o SPOUSE'S NAME
- o SPOUSE'S OFFICE NUMBER
- o OTHER

OUR OFFICE PROMISES NOT TO RELEASE ANY INFORMATION ABOUT YOU UNLESS YOU HAVE SPECIFICALLY SPECIFIED IT BELOW OT HAVE PERSONALLY GIVEN YS WRITTEN PERMISION TO DO SO.

PLEASE LIST ANY PERSON BELOW THAT WE MAY RELEASE YOUR PERSONAL INFORMATION TO.

____

____

____

PATIENT SIGNATURE OR LEGAL GUARDIAN________________________________

DATE_____________

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

____________________	____________________	____________
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

____________________	____________________	____________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Jennifer M. Smith, D.C.
1051 Town Center Drive, Orange City, FL 32763
Office: (386)775-3600 * Fax: (386)775-3602

Dr. Jennifer M. Smith
Chiropractic Physician

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER

I ________________________________ hereby instruct and direct my insurance company pursuant to Florida Statute F.S.627.422 to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services, and any reimbursements otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by them. The payment is not exceed my indebtedness to the above name provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability or any other health or medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above named provider.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes the right to recover any attorney's fees and costs for such an action brought by the provider as my assignee.

I also agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for payment of services provided by them.

I also authorize the release of any information pertinent to my case or claim to the above name provider or any attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above name provider to file any formal or informal complaints that are necessary to the Insurance Commissioners Office or any other agency or court they deem appropriate on my behalf.

SIGNATURE OF CLAIMANT (PATIENT)

[________________________________ ________________________________

CLAIMANT (PATIENT) DATE

IF POLICY HOLDER (INSURED) IS SOMEONE OTHER THAN PATIENT

________________________________ ________________________________

SIGNATURE OF POLICY HOLDER DATE

Health and Wellness Chiropractic Center
1051 Town Center Drive, Orange City, FL 32763
Office: (386)775-3600 * Fax: (386)775-3602

TO____

____

____

RE: HEALTH RECORDS AND PROVIDER'S LIEN

I do hereby authorize the above provider, Health and Wellness Chiropractic Center, to furnish you, my attorney, with a full report of this examination, diagnosis, prognosis, etc.; of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Health and Wellness Chiropractic Center such sums as may be due and owing them for medical services rendered me both by reason of this injury and by reason of any other bills that are due their office and to withhold sums from and settlement, judgment or verdict as may be necessary to adequately protect said provider. I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by them for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

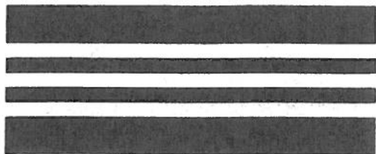
I forbid you, my attorney, from paying my provider any sums less than the full amounts owed to said provider, without its written consent.

Dated:________________ Patient's Signature:____

The undersigned being attorney of record for this above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider above named.

Dated:________________ Attorney's Signature:______________________________________

PLEASE
DO NOT
STAPLE
IN THIS
AREA



APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __

2. ___ . __

3. ___ . __

4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500