EL-KHALIL FOOT AND ANKLE SPECIALIST

Accident Questionnaire

Patient Name: _____

TYPE OF CLAIM: Worker Comp: _____ Auto: _____

Other: _____

Date of Injury: _____

Claim Number: _____

Name of Insurance: _____

Claim Address: _____

_____

Claim Adjuster/ Contact Name: _____

Phone Number: _____

**** For Auto Accidents ****

Amount of Deductible: $_____

(if Applicable)

Coordinated benefit means you have to submit the clams to their health insurance first then to their auto insurance. Non-Coordinated benefit means that you will submit claims directly to the auto insurance. Some policies also have deductibles.

_____ COORDINATED BENEFITS

_____NON-COORDINATED BENEFITS

**** If this is a coordinated benefit, please attach a copy of the front and back of their medical insurance cards. Please include the subscriber's social security number, date of birth, and relationship to patient. ****