Adair County Health System
we surround you with care

Adair County Medical Clinics

Automobile Accident Information

The following is information required for submitting work-related injury to work-related illness charges to your worker's compensation insurance company.

If you do not or are unable to give complete information, the charges will be your responsibility until such time as information is provided to us.

Patient Information		
Patient Name:	DOB:	Date:
Sex: ☐ Male ☐ Female		

Date of Accident:		Was law enforcement on the scene? ☐ Yes ☐ No	
Who was at fault?			
Were you considered working at the time of the accident? ☐ Yes ☐ No			

Automobile Insurance Please provide the full mailing address and information listed below.		
Company Name**:**		Phone:
Address:		
City:	State:	ZIP
Policy Number (if known) or Insurance Agent:		

Employer's Worker's Compensation Insurance Company Please provide the full mailing address and information below.		
Insurance Company Name:		Phone:
Address:		
City:	State:	ZIP
Claim Number (if known):		

Authorization for Release of Medical Information	
I authorize the release of medical information and/or copies of my health records to the above named insurance company for the purpose of determining automobile insurance benefits related to the injury / illness that occurred on:	
Date of Injury:	
To Body location or injury- be specific:	
Signature:	**Date:**
Witness:	**Date:**

(If patient is unable to sign, but uses X or mark)