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Auto Accident/Workers Comp Billing Information

Patient Name: _____ DOB: _____

Date of Injury: _____
Comp



Auto Accident



Workers

Insurance Company*: _____

Mailing Address: _____

Claim Number: _____

Adjuster's Name: _____

Phone Number: _____

Fax Number: _____

E-mail address: _____

*If auto related, listed insurance should be their own policy (not the other involved party).

Fax to Mid-Atlantic Medical Billing & Coding at (866) 215-8428