Baltimore NEUROSURGERY and SPINE CENTER

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ACCIDENT RELATED INSURANCE
WORKERS COMPENSATION, CAR INSURANCE, & OTHER 3RD PARTY LIABILITY

Please complete this form, if it applies to you. This will allow us to get your claims to the correct persons.
This form is confidential and will be kept as part of your medical record.
If you should have any questions about this form, please call our office at (410) 664-3680.

Patient Information

First Name	Middle Initial	Last Name	Birth Date	Age	Sex

Address	City	State	Zip Code

Home Phone ( )	Cell Phone ( )	Social Security #

Employer Name	Employer Phone	E-Mail Address

Employer Address	City	State	Zip Code

Claims Information

Name of Carrier	Claim #	Date of Injury/Accident

Billing / Claims Address	City	State	Zip Code

Adjusters Name, if applicable	Phone

Attorney Information

Name	Phone	Fax

Address	City	State	Zip Code

I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all fees incurred with Baltimore Neurosurgery and Spine Center. I authorize payment of medical benefits to the provider or supplier for all services rendered if the provider of services is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE _____ **DATE** _____/_____/_____