United Family Medicine
A COMMUNITY CLINIC

Patient Label:

THIRD PARTY INFORMATION

Please complete the following information and mail it back to our clinic. We will then bill your LIABILITY INSURANCE. If you have questions please call Joyce at: (651) 241-1089.

Patient Name_____

Patient DOB:_____

Patient SSN:_____

Body Part Injured:_____

Date of Injury:_ _____

Claim Number:_____

Subscribers Name:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone #:_____

Adjuster Name:_____

Adjuster Phone #:_____