THE REHAB CENTRE

Maple's premier rehab and wellness centre

MVA INSURANCE FORM

NAME _____ DATE OF ACCIDENT dd_____ mm_____ yyyy_____

INSURANCE COMPANY _____

ADDRESS _____

DO YOU HAVE EXTENDED HEALTH CARE COVERAGE?: Y ☐ N ☐

ADJUSTOR _____

PHONE ( ) _____ FAX ( ) _____

CLAIM # _____ POLICY # _____

ACCIDENT DETAILS:

Did you require to be taken by ambulance to the hospital?: Y ☐ N ☐ If yes, answer a,b & c

a. If yes, which hospital? _____ Were you required to stay?: Y ☐ N ☐

b. Were any tests or diagnostic studies done? _____

c. Were any medications recommended or prescribed? _____

Did you receive medical attention at the scene?: Y ☐ N ☐

Did you see your family medical doctor?: Y ☐ N ☐ If yes when?:_____

Were any tests or diagnostic studies done? _____

Were any medications recommended or prescribed? _____

DESCRIPTION OF ACCIDENT:

Where did the accident take place? _____

What type of vehicle were you driving?_____ Were you the driver ☐ passenger ☐

What was the other type of vehicle involved in the accident?_____

Additional details about the accident:

_____

_____

_____

_____

Illustration of accident

IF FOR ANY REASON THE INSURANCE COMPANY WILL NOT ACCEPT OR DISCONTINUES YOUR CLAIM, YOU ARE RESPONSIBLE FOR ALL CHARGES ASSOCIATED WITH YOUR THERAPY.

_____ _____

Signature Date