CROSSROADS MEDICAL GROUP
A LifeBridge Health Medical Group

Integrative Medicine
AT CROSSROADS
Conventional and complementary medical services

ACCIDENT INFORMATION FORM

Patient's Name:

Date of Accident:

Claim #

Type of Claim: ☐ Auto Accident ☐ Work-Related Injury ☐ Other ☐

Accident Insurance Information:

Name of Insurance Company:

Address of Insurance Company:

Claim Adjuster's Name:

Adjuster's Phone Number:

Note: Please complete ALL sections to allow for your claim to be billed to the appropriate insurance company. This Information replaces your medical insurance and will billed for your office visits(s).

You may also fax your completed form to our Billing Department (410.997.5377).