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MOTOR VEHICLE ACCIDENT

Authorization for Release of Information and Payment of Medical Benefits

****Form must be complete in order to bill your auto insurance company****

Insurance Company Name: _____
(insurance for the vehicle the patient was driving or was a passenger in)

Billing Address: _____

Policy Number: _____

Date of Accident: _____

Policy Holder: _____

Claim Number: _____

Adjustor's Name: _____

Adjustor's Phone: _____

I authorize the release of medical information necessary to process the attached claim and request that payment of medical benefits be made directly to West Linn Family Health Center.

I understand that West Linn Family Health Center is billing my motor vehicle insurance as a courtesy and payment is due by me if payment is not received within 30 days from my motor vehicle insurance company.

Patient Name _____

Signature _____
(patient or guardian signature)

Date _____