AUTO INSURANCE CHECKLIST SHEET

Patient Name_____Today's Date___/____/_____

Date of Birth ___/____/_____ Cell Phone Number _____

Your Auto Insurance Carrier _____

USING THE PHONE NUMBER FROM YOUR INSURANCE CARD, ASK THE REP THESE QUESTIONS:

CLAIM NUMBER_____

CLAIMS ADDRESS_____

DATE OF ACCIDENT_____

ADJUSTER NAME_____

ADJUSTER PHONE_____

ASK "WHAT COMPANY HANDLES PRE-CERTIFICATIONS?"

PRE-CERT COMPANY_____

PRE-CERT ADDRESS_____

PRE-CERT FAX_____

ASK "IS AUTO INSURANCE SET AS PRIMARY PAYOR FOR PIP MEDICAL CLAIMS?"

❒ YES, AUTO INSURANCE THE PRIMARY PAYOR FOR AUTO MEDICAL CLAIMS

❒ NO, MY MEDICAL INSURANCE IS THE PRIMARY PAYOR FOR AUTO MEDICAL CLAIMS

ASK "IS THERE A DEDUCTIBLE FOR MY PIP MEDICAL CLAIMS?"

❒ No Deductible ❒ Yes Deductible, Amount of $_____

ASK "IS THERE A CO-PAYMENT/CO-INSURANCE FOR MY MEDICAL CLAIMS?"

Co-pay/Co-insurance Amount of $_____

ASK "ARE THERE ANY POLICY LIMITS?"

❒ No Policy Limits ❒ Yes Policy Limits, Amount of $_____

ASK "CAN YOU EMAIL ME A COPY OF MY AUTO DECLARATIONS PAGE?"

(After the call, you will forward this E-mail to contact@NJnerve.com)

SAY "THANK YOU, CAN I PLEASE HAVE YOUR NAME AND A REFERENCE NUMBER?"

Name_____

Reference #_____