



*In Partnership with Physician Owners*

## **OTHER LIABILITY FORM/ MOTOR VEHICLE ACCIDENT**

Dear Patient:

We understand that you have been in either an auto accident or incurred an injury where a third party is responsible. Please answer all of the questions on this form and return the accident information within the first **7 days from the surgical procedure**. **If we do not receive this information, you will be directly responsible for the entirety of the cost of your procedure.**

This accident information will allow Sequoia Surgical Pavilion to correctly bill the third party's insurance that is responsible for the medical expenses due to your accident. Our office will process the information in order to ensure that the medical claim is billed correctly. Incomplete accident information and documentation will delay the billing process and you will immediately begin receiving statements for your balance.

For billing purposes, you will need to provide both the third party (auto/other) and medical insurance information. Per facility policy, the third party (auto/other) insurance will be billed first. After they have responded via payment or denial, we will then bill your medical insurance for any remaining balance. If there is an attorney involved, all contact information must be provided. If you have any questions, please call 925-935-6700 and speak with our insurance verifier or biller.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Witness: \_\_\_\_\_

## Sequoia Surgical Pavilion

### Personal Information:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

### Accident Information:

Accident Date (mm/dd/yyyy): / \_\_\_\_ / \_\_\_\_  
Location: (street address / intersection/ city / state): \_\_\_\_\_  
Police Agency: \_\_\_\_\_ Police Accident Report #: \_\_\_\_\_  
\_\_\_\_\_

### 3rd Party Auto Insurance:

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Adjustor's Name: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Form of Coverage: \_\_\_\_\_ (liability/medical)  
\_\_\_\_\_

### **ATTORNEY INFORMATION (If Applicable)**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Law Firm: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

### Health Insurance Information:

Health Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
Address: \_\_\_\_\_