5901 Harper Dr NE
Albuquerque, NM 87109
Ph: 505-848-3730 Fax: 505-217-2730

Infectious Diseases & Internal Medicine Associates, PC *(IDIMA)*

ACCIDENT FORM

If your injuries are due to an accident please complete this form in its entirety to ensure claim submission.

Patient Name: _____ DOB: _____

Policy#: _____ Claim #:_____

Date of Incident: _____ Location of Incident: _____
(ex: work, motor vehicle, etc.)

Injury description: _____
(ex: broken leg, back pain, twisted ankle, etc.)

Who do we contact for payment?

Adjuster Name :_____

Company Name: _____

Claims Address: _____

_____

Phone: _____ Fax: _____

Visits Approved: _____

Other Information:_____

_____

_____ _____
Adjuster Signature Date

I understand if payment is not received from the above responsible party within 90 days from the date of service, I am liable for the balance due in full. IDIMA will NOT bill my primary medical insurance since claims are due from a 3rd party liability, unless specifically requested to do so in writing from the patient.

_____ _____
Signature Date

_____
Print Name