MVA FORM

******If for any reason insurance will not accept your claim, or does not approve all treatments required, you are responsible for all charges*****

Personal Information

Name:		
Home Address:		
City/Town:	Province:	Postal Code:
Home Phone:	Cell Phone:	
Date of Birth:	Claim#:	

Primary Insurance (Extended Health Care) Information

Company Name:		
Company Address:		
City/Town:	Province:	Postal Code:
Business Phone:	Ext:	Fax Number:
Policy #	Identification #	Group#

Secondary Insurance (Auto) Information

Representative Name:		
Company Name:		
Company Address:		
City:	Province:	Postal Code:
Business Number:	Ext:	Fax Number:
Claim #	Policy #	Date of Loss:

Lawyer

Lawyer Representative:	
Company Name:	
Full Address:	
Phone Number:	Fax Number:

Family Physician:

Family Physician:	
Full Address:	
Phone Number:	Fax Number:

Description of Accident:

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If for any reason your MVA claim (compensation) is not accept, or does not approve all completed treatments required, you are responsible for all charges. All outstanding treatment fees will revert back to the standard clinic fees as per Office Policy fee schedule. A Credit Card Number is needed on file.

Visa ☐ Master Card ☐

Card Number ______________________________ Expire Date______________

Print Name: ______________________________ **Date:** ___________________________

Signature: ______________________________