HCFS

In order to process your account this additional information is needed. If you fail to provide this information, we cannot submit a claim on this account and the entire balance of this patient's account will become your responsibility.

Patient Name:_____

Hospital:_____**Account number:**_____

ACCIDENT INFORMATION:

Accident Date: _____ Time: _____ County: _____

Place of Accident: _____

Nature of Accident: _____

Police Authority Involved: _____ Case #: _____

Driver of Auto Patient was in: _____ Address: _____

Is there an attorney involved: YES NO Name: _____

Contact number: _____ Address: _____

AUTO INSURANCE INFORMATION ON AUTO PATIENT WAS IN:

Insured Name: _____ D.O.B: _____

Name of ins. company and/or agency & Location: _____

Policy Number and/or claim number: _____

Adjuster Name and contact number: _____

AUTO INSURANCE INFORMATION ON AT-FAULT DRIVER:

Insured Name: _____ D.O.B: _____

Name of Ins. company and/or agency & Location: _____

Policy and/or claim number: _____

Adjuster Name and Contact Number: _____

OTHER PATIENTS THAT WERE INVOLVED IN ACCIDENT:

In Auto w/ Pt.?

Name: _____ Acct.# _____ YES or NO

Name: _____ Acct.# _____ YES or NO

Health insurance? YES or NO ***Card ?*** YES or NO ***Copy scanned?*** YES or NO

Carrier Name and phone number:: _____ Policy # _____

MISCELLANEOUS NOTES:

_____

HCFS, Inc.
3011 Internet Blvd., Suite 100
Frisco, TX 75034

Form completed by: _____
Ph. 1.800.394.4237 ext 2193 or 2194
Fax 972.767.3506