ASSOCIATED ORTHOPEDISTS OF DETROIT, P.C.

MICHAEL R. DEMERS, M.D.; STEVEN J. CUSICK, M.D.; KENNETH R. CERVONE, M.D.; BENEDETTO P. PELLERITO, M.D.;
JAMES D. BOOKOUT, M.D.; SHARIFF K. BISHAI, D.O.; ANDREW F. AJLUNI, D.O.; SAMER G. SAQQA, D.O.;
ANTHONY P. CUCCHI, D.O.; MATTHEW M. BREWSTER, D.O.

24715 LITTLE MACK AVENUE, SUITE 100
ST. CLAIR SHORES, MI. 48080
(586) 779-7970
(586)779-7748 (FAX)

50505 SCHOENHERR ROAD, SUITE 120
SHELBY TOWNSHIP, MI. 48315
(586) 412-1411
(586) 412-4626 (FAX)

WWW.ASSOCIATEDORTHO.ORG

MICHIGAN NO FAULT AUTO BILLING INFORMATION

- DATE OF ACCIDENT:_____LOCATION OF ACCIDENT: _____
  CITY COUNTY

HOW DID ACCIDENT OCCUR? _____

- PATIENT NAME:_____SSN:_____
- DATE OF BIRTH:_____ TELEPHONE #:_____
- ADDRESS:_____
  STREET CITY STATE ZIP
- WERE YOU THE DRIVER?_____ PASSENGER?_____OTHER/EXPLAIN_____
- AUTO INSURANCE COMPANY NAME: _____

ADDRESS: _____
STREET CITY STATE ZIP

TELEPHONE #:_____WAS CLAIM FILED? YES____ NO____

CLAIM REPRESENTATIVE: _____CLAIM #_____

POLICY # OF AUTO INSURANCE CARRIER: _____

NAME OF INSURED: _____

- IS THERE ANY DISPUTE WITH YOUR AUTO INSURANCE CARRIER? YES____ NO____
- IS THERE A "CASE MANAGER" INVOLVED? _____
- IS YOUR AUTO POLICY COORDINATED WITH YOUR HEALTH INSURANCE? YES___ NO___

- PLEASE FURNISH THE FOLLOWING HEALTH INSURANCE INFORMATION TO US FOR BILLING PURPOSES IF NEEDED:
- INSURANCE NAME:_____

ADDRESS: _____

POLICY NUMBER(S):_____

SUBCRIBER NAME: _____

PATIENT SIGNATURE: _____DATE_____