RPI THERAPY SERVICES

Motor Vehicle Accident (MVA) Questionnaire

Patient Name: _____ Date: _____

Date of Accident: _____

Patient's Lawyer's Name & Address: _____

_____

_____

Patient's Insurance Name & Address: _____

_____

_____

Referring Doctor: _____

Other Party's Lawyer's Name, Address & Contact Info: _____

_____

_____

Other Party's Auto Insurance Name, Address & Contact Info: _____

_____

_____

Was the patient at fault? ☐ Yes ☐ No

Who is responsible for payment? _____

Claim / Authorization Number: _____

Have any other Medical Bills been made regarding this auto accident? ☐ Yes ☐ No If yes, how much (approx.)? **$**

Do you wish for Medical Insurance to be billed? ☐ Yes ☐ No If yes, please initial _____

Patient Signature: _____

FOR THERAPIST USE ONLY:

Therapist Name: _____

Location (RH or CH): _____

Estimated Date of *Discharge* / Estimated *Amount of Visits*: _____

This questionnaire is for Lien Letter purposes only. *1/25/11*