OLD GREENWICH MEDICAL GROUP

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CLAIM INFORMATION REQUEST

Patient Name: _____ DOB: _____

Hello

The above-named patient was seen in our office on: _____

I attempted to call you for this information on: _____

Please provide requested information via FAX to (203) 637-5408. Please contact Karyna with any questions.

I authorize and request you to release records to: Old Greenwich Medical Group, Billing Department

Signature: _____

Please provide the following information for billing purposes:

1. Claim Number
2. Company name and claims billing address
3. Date of loss
4. State of incident
5. Injured body part
6. Adjuster's Name – Telephone number – Fax number
7. Is patient's condition related to employment?

ATTN: _____

Phone: _____

Fax: _____