



MOTOR VEHICLE INSURANCE QUESTIONNAIRE

Thank you for choosing Rice Memorial Hospital for your health care needs.

So that we can process your claim correctly, please fill in the injury details below. Bring this form to your Insurance Agent to complete and return to our Business Office.

Please complete and return this form within 48 hours

PATIENT _____ ACCOUNT NO: _____

Injury Date: _____ Time: _____

Accident Location: _____

Accident Details (What happened?) _____

Policy Holder: _____ Relationship to Patient: _____

Policy Number: _____ Claim Number: _____

Insurance Name: _____

Insurance Address: _____ City: _____

Telephone Number: _____ State: _____ Zip: _____

Name of Insurance Agent: _____ Telephone: _____

Please FAX this questionnaire to our Business Office at 1-320-231-4879.

Auto Quest 4/00

