# NOTICE TO ALL LIABILITY CLAIMANTS

Any patient requesting ORA to process your liability claim, whether it is from a personal injury claim or a motor vehicle accident, will need to complete this form. If at the time of your visit you do not have this information to provide to our insurance department, your account will be set up as self-pay until we receive this. If you have any questions regarding this, you may call and speak to anyone in the business office. The phone number can be found at the bottom of this page.

Patient Name: _____ Date of Birth: _____

☐ Personal Injury ☐ Motor Vehicle Injury

Body Part Injured: _____

Date of Injury: _____

☐ Med Pay Claim ☐ Third Party Claim

Claim #: _____

Agent/Claim Adjuster Name: _____

Send Bill To: _____
Name of Insurance Company

_____
Address

_____ _____ _____
City State Zip Code

_____ _____ _____
Phone Number Extension Fax Number

| *Crow Valley Office* | *Davenport Office* | *Moline Office* |
|---|---|---|
| □ Attn: Val L. | □ Attn: Rebecca L. | □ Attn: Kayla W. |
| Phone: (563) 459-4023 | Phone: (563) 459-4015 | Phone: (309) 757-5072 |
| Fax: (563) 324-0615 | Fax: (563) 322-0051 | Fax: (309) 736-3570 |