



Penn Medicine

Princeton Health

Patient Access Services
Penn Medicine Princeton Medical Center
1 Plainsboro RD
Plainsboro, NJ 08536

Patient Name: _____ Acct#: _____ DOS: _____

You've been given this letter because you have sought medical care due to a work or motor vehicle related injury, which may be covered by Worker's Compensation or No Fault/Auto Insurance. We will be pleased to send the bill for our services to the appropriate insurance company.

Complete the following information and return to our office within ten (10) days. If we do not receive this information, we will bill you directly and you will be financially responsible to the hospital for charges not covered. Note that your regular health insurance may not pay for these services if they should be paid by the Worker's Compensation or No Fault/Auto Insurance carrier.

Information can be faxed to 609-853-7865 or returned in the attached envelope.

Please call Patient Access Services at (609) 853-7095 if you have any questions or need assistance completing this form.

Note: Only complete the section that applies

Workers Compensation Related Injuries-please provide requested information:

Insurance Co.: _____ Claim #: _____

Insurance Co. Address: _____

Telephone #: _____

Employer Name: _____ Employer Address: _____

_____ Date of Injury: _____

Subscriber Name: _____ Subscriber Sex: _____ DOB: _____

Motor Vehicle Related Injuries-please provide your No Fault information:

Name of Motor Vehicle Policyholder: _____ Policy Holder Sex: _____

DOB: _____ Name of Insurance Company: _____

Insurance Company Address: _____

_____ Telephone: _____ Policy Eff Date: _____

Policy number: _____ File/Claim Number: _____

Please provide your health/medical insurance information in the event that the entire claim is not covered by Workers Compensation or No Fault/Auto Insurance.

Insurance Co.: _____ Policy ID/Group#: _____

Insurance Co. Address: _____

Telephone #: _____ Employer Name: _____

Subscriber Name: _____ Subscriber Sex: _____ DOB: _____

Insurance Eff Date: _____