



Payor/Contact Information

Are you working with an Attorney?

Yes

No

Attorney's Name: _____

Law Office: _____

Phone #: _____

Are you working with a Medical Lien?

Yes

No

Case Manager Name: _____

Phone #: _____

Is this a Workman's Comp Claim?

Yes

No

Workman's Comp Company Name: _____

Adjuster Name: _____

Phone #: _____

Is an Auto Insurance Company responsible for payment?

Yes

No

Auto Insurance Company Name: _____

Claim # (if applicable): _____

Contact Person: _____

Phone #: _____

Please list ALL doctors involved in your care, including address, phone, and fax numbers.

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

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