Duluth Family Medicine Clinic

Auto Accident Claim

You have requested we file an Auto Accident Claim.
In order to file this claim, you must complete all of the following information.

Tell us about your injury:

Date of Injury: _____

What did you injure? (Ex: Lower Back) _____

Is this your initial visit? Yes No

If no, please list date of initial visit and any subsequent visit dates: _____

Tell us about the insurance provider to bill for the claim:

Insurance Carrier: _____

Address: _____

Phone Number/Contact Person: _____

Claim Number: _____

If you should require any follow-up appointments relating to this injury, please inform the receptionist at the time of scheduling.

Patient Signature: _____

Patient Name (Please Print): _____

Patient Date of Birth: _____

Today's Date: _____

Please submit completed form to:
Duluth Family Medicine Center
330 N 8th Ave E Duluth, MN 55805
Phone: 218-723-1112 / Fax: 218-529-9120