



Instant Medical Care

3262 Vineland Road, Unit 102
Kissimmee, FL 34746
Phone: 407-397-8937
FAX: 407-397-9547

Insurance Verification Form

Patient Name _____ Date of Birth _____

Patient Address _____

Social Security # _____

Home Phone # _____ Work Phone# _____ Cell Phone# _____

PIP ___ W/C ___ Reg. Health Insurance _____ Date of Injury _____ Injured in FL Yes ___ No ___

At the time of the Accident, were you the: Driver ___ Passenger ___ Pedestrian ___

Do you own a vehicle: Yes ___ No ___: If yes, Year _____ Make _____ Model _____

Year _____ Make _____ Model _____

Year _____ Make _____ Model _____

If you do not own a vehicle, do you reside with a resident relative that owns a vehicle: Yes ___ No ___: If yes, who insures that resident relative's vehicle _____

Have you reported the claim: Yes ___ No ___: If yes, what's the date you reported the claim: _____

Insurance Carrier _____ Phone # _____

Address _____

Claim # _____ Policy # _____

Adjuster _____ Phone # _____ Fax # _____

Ref By _____ Phone # _____

Auto carrier: Pays @ _____ %, Deductible _____ (\$ _____ met) Med Pay _____

Attorney _____ Phone # _____ Fax # _____

Address _____

LOP Requested on _____ Received on _____

Other _____
