NATIONAL HEALTH FINANCE
& AFFILIATE COMPANIES

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# Evaluation/Care Form

Referred By: _____ Treatment Requested For Funding: _____
(E.g. PT, MRI, Ortho, etc.)
Contact Person: _____ Phone: _____ Email: _____

Case Type: MVA S&F BI Other _____ Date of Loss: _____

**Patient/Client Information**

Name: _____ SSN: _____ DOB: _____

Full Address: _____

Phone Number: _____ Email: _____

Preferred Language: English Spanish Other_____

Attorney Represented? If yes, name and phone number: _____

**Accident Description/Information** *If police report is available please provide NHF with copy of the report.

Police? Yes No Department _____ Report Number: _____

Type of MVA: Rear end Sideswiped (driver / passenger) Red light running Illegal Left Turn Other _____

Brief Description: _____

Number of Claimants _____

**Is this a workman's compensation case?** Yes No

**Has client been involved in a prior accident?** Yes No **Does client have any pre-existing health conditions?** Yes No

If yes, provide with date of incident(s) and type of injuries sustained in each AND/OR state the nature of your clients pre-existing conditions:
_____

**Adverse Insurance/Defendant Information**

Liability Accepted? Yes No Investigating Limits Disclosed? Yes No Coverage _____

Insured Name: _____ Insurance Company: _____

Policy OR Claim Number: _____ Phone Number: _____

**Patient/Client Insurance Information:** Type of Coverage/Limits UM _____ UIM _____ Medpay _____ PIP _____

Insurance Company: _____ Phone Number: _____

Policy OR Claim Number: _____

Is Patient/Client a Medicare or Medicaid insured? Yes No Is Patient/Client Medicare or Medicaid eligible? Yes No

**Medicals/Miscellaneous**

Ambulance? Yes No Hospital? Yes No Additional treatment to date? X-Rays MRI Specialty/Other? _____

Medical Bills to Date: _____ Injuries: _____

Our vehicle year, make, model _____ Property Damage? Total Loss Repairable _____

Adverse vehicle year, make, model _____