

Claimant Information Form

Date: _____

Claimant Name: _____

Date of Birth: ____/____/____ Sex: _____ SSN: ____-____-____

Address: _____

City, State, Zip Code: _____

Name of Parent/Guardian 1: _____ Phone No. _____

Cell No. _____ Email Address: _____

Name of Parent/Guardian 2: _____ Phone No. _____

Cell No. _____ Email Address: _____

Primary Physician Name: _____

Primary Physician Telephone Number: _____

Primary Physician Fax Number: _____

INSURANCE INFORMATION (other than the Birth Injury Program)

Primary Insurance Carrier: _____ Telephone Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Subscriber Name: _____

Other Insurance Carrier: _____ Telephone Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Subscriber Name: _____

Dental Insurance Carrier: _____ Telephone Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Subscriber Name: _____