Wensong Li United Interventional Pain Management

NO FAULT

INSURED: _____

INJURED PATIENT: _____

INSURANCE COMPANY: _____

ADDRESS: _____

_____

POLICY NUMBER: _____

INSURANCE AGENT: _____ _____

PHONE NUMBER: _____ _____

DATE OF ACCIDENT: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____

Please provide reception with your No-Fault Insurance card.

I authorize this office to submit medical claims to the above mentioned insurance carrier on my behalf. The insurance company my pay this office or its representatives directly for these services.

Signature/date: _____