



THANK YOU for choosing the hospitals and physicians of BAPTIST HEALTH as your healthcare provider. BAPTIST HEALTH is committed to fulfilling our mission of delivering the highest quality care to you and your family.

MOTOR VEHICLE ACCIDENT GUIDELINES

We understand that you have been in an auto accident. Please answer all questions completely and return the accident information within the first 7 days after you are discharged from BAPTIST HEALTH. If we do not receive this information, you will be directly responsible for the entirety of the cost of your hospital stay.

This accident information will allow Baptist Health to correctly bill the auto insurance that is responsible for the medical expenses due to your motor-vehicle accident. Our office will process the information in order to ensure that the medical claim is billed correctly. Without complete accident information and documentation, you will immediately begin receiving statements for your remaining balance.

For billing purposes, you will need to provide both your auto insurance and medical insurance information (even if another party is at fault). Per hospital policy, your auto insurance will be billed first. After they have responded via payment or denial, we will then bill your medical insurance for any remaining balance. Your auto insurance will then resolve any issues outstanding with other responsible parties and their insurance carriers. If there is an attorney involved, all contact information must be provided. Unless your accident is work-related, we are unable to bill any third party or their insurance without written consent.

Please return this information in the self-addressed envelope.

Mail To: BAPTIST HEALTH
Patient Financial Aid Office
9601 Interstate 630, Exit 7, Box 57
Little Rock, AR 72205-7299

PLEASE RETURN THIS INFORMATION PROMPTLY TO AVOID BEING PERSONALLY RESPONSIBLE FOR YOUR REMAINING BALANCE. If you have any questions, please call Patient Financial Services at (501) 202-3904 or (501) 202-3933.

Account #: _____ Account #: _____ Account #: _____

MOTOR VEHICLE ACCIDENT INFORMATION

PERSONAL INFORMATION

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Work #: _____ Cell #: _____

ACCIDENT INFORMATION

Accident Date (mm/dd/yyyy): ____ / ____ / ____
Location: (street address / intersection / city / state): _____
Police Agency: _____ Police Accident Report #: _____

PERSONAL VEHICLE INFORMATION

Owner: _____
Address: _____
State: _____ Zip Code: _____
Phone #: _____
Driver's Name: _____

3rd PARTY VEHICLE INFORMATION

Owner: _____
Address: _____
State: _____ Zip Code: _____
Phone #: _____
Driver's Name: _____

PERSONAL AUTO INSURANCE

Insurance Company: _____
Subscriber's Name: _____
Policy #: _____
Claim #: _____
Agent / Adjuster: _____

3rd PARTY AUTO INSURANCE

Insurance Company: _____
Subscriber's Name: _____
Policy #: _____
Claim #: _____

Form of Coverage (circle all that apply): Liability / Medical

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(In order for BAPTIST HEALTH to be able to contact the insurance company on your behalf, you must sign an 'Authorization to Release Information' form.)

HEALTH INSURANCE INFORMATION

Health Insurance Company: _____
Policy #: _____

Subscriber's Name: _____
Group #: _____

ATTORNEY INFORMATION (If Applicable)

Name: _____ Law Firm: _____
Address: _____ Phone #: _____