

Verification of Claims Information

Dr. Timothy Gallagher

Personal Injury / Worker Comp. Only

(Doctor's office should verify Insurance information)

Patient: _____

Name of Insurance Company: _____

Ins. Company Mailing Address: _____

City: _____ State: _____ Zip: _____

Ins. Company Telephone #: (_____) _____

Date of Injury or Accident: _____

Claim #: _____

Adjusters Name: _____ Tel: _____

ATTORNEY INFORMATION

Name of Law Firm: _____

Attorney Name: _____

Telephone: () _____ FAX: () _____

Address: _____

City: _____ State: _____ Zip: _____