HAND SURGERY of Northern Michigan

SURGERY OF THE WRIST AND HAND

Mark S. Leslie, M.D. | Paul A. Jacobson, M.D. | Danielle A. Conaway, M.D.

AUTO LIABILITY AUTHORIZATION

Dear Patient:

In order to minimize billing difficulties with your auto insurance, we need to have your adjustor provide us with the following information. Please have your agent complete the information below and have them fax this form back to us.

Thank you for your assistance in this matter.

This will authorize payment to *Hand Surgery of Northern Michigan* for treatment rendered to

_____ who was injured on _____.

Auto Insurance Name: _____

Address: _____

_____

Policy Holder Name: _____

Claim #: _____

Agent Name: _____

Agent's Phone #: _____

Signed: _____

Is patient's health insurance primary? *Yes* ☐ *No* ☐

701 W. Front Street, Ste. 100
Traverse City, Michigan 49684
P: (231) 935-0800
F: (231) 935-0808