Main Line HealthCare
Physician Network

Case Registration Form

TO: Collection Supervisor FAX: 484-565-1690

Patient Name _____

Patient SS # _____ **Patient Date of Birth** _____

Account # _____ **Today's Date** _____

Date of Patient's First Service Related to this Case: _____

Please complete this form in order to ensure the proper billing of your services.

Case Information

Insurance Company Name: (MVA/WC)	
Insurance Company Address 1:	
Address 2:	
Insurance Co. City, State:	
Insurance Company Zip:	
Adjustor Name	
Insurance Co. Phone #:	
State of Accident: (Auto)	
Injury Type:	❑ Workers' Comp ❑ Automobile ❑ Other _____
Injury Date:	
Claim Number:	
Policy Number:	

Policyholder/Employer Information

Policyholder/Employer Name	
Address 1:	
Address 2:	
City, State, Zip	
Phone #:	
Patient Relationship to Insured/Policyholder	❑ Self ❑ Spouse ❑ Child ❑ Other _____
Policyholder DOB	

If a Legal Case, please complete the following:

Attorney's Name:	
Attorney's Address:	
Attorney's City, State, Zip:	
Attorney's Phone Number:	

Completed by: _____ **Date:** _____

Note: Please send office notes via interoffice mail for this case to: Collections Supervisor @ CBO

Form # REG – Updated 10/9/2012