

**AA AUTHORIZATION**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

AGENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE # \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE #: \_\_\_\_\_

ADJUSTOR: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

LAWYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE #: \_\_\_\_\_

MEDICAL COVERAGE: \_\_\_\_\_