Patient:_____

Date of Birth:_____/_____/19____

Address:_____

City/State/ZIP:_____

Telephone:_____

Provider Name: _____

Re: Insurance Payments for Accident-Related Injuries

Dear Provider:

Please be advised that I am treating with your office for injuries sustained in a motor vehicle collision on or about _____/_____/201___. I have No-Fault PIP coverage through my auto insurance policy with _____. My claim number for this accident is _____. My insurance company has assigned a medical adjuster to my file, named _____ who can be reached by telephone at (_____)_____-_____.

Please bill my auto carrier as primary. Additionally, be aware that you must provide "notice of commencement of treatment" within 21 days of my first office visit. Please also ensure that all treatment rendered 10 days after the date of loss is pre-certified with my carrier.

If, *and only if*, there is a remaining balance due to my PIP policy's deductable and co-pay, **please bill my private health insurance as secondary**. I have health insurance with _____. My Member ID is _____ and I can provide you a copy of my insurance card upon request. I explicitly *do not* authorize you to bill my private health insurance until the treatment has been submitted for payment to my PIP as primary.

Thank you for your kind attention to this matter.

Date:_____/_____/201_____ Signed:_____