Thank you for choosing Milford Regional Physician Group for your recent medical needs. You reported to us that this visit was due to a **Workers Compensation or Motor Vehicle** accident. For our third party billing company, Partners Healthcare, to correctly bill your **Liability Carrier** claim we will need the following information.

Patient Name: _____ Medical Record #: _____

Facility patient was seen at: _____

Liability Carrier: _____

Address: _____

Phone Number: _____

Claim #; _____ Date of Injury: _____

Adjuster: _____

Type of Injury: _____ Date of Birth: _____

Health Insurance: _____ Address: _____

Subscriber: _____ Policy #: _____

If MVA-
Were you the: Driver _____ Passenger _____ Pedestrian _____

If Work Comp-
Employer Name: _____

Address: _____

Contact: _____

Phone Number: _____

Please provide us with the following information on this form **within 14** days using one of the following methods:

Phone 857-282-0500
Fax 857-282-9921
Email PHSTPLUNIT@PARTNERS.ORG

Patient Label

Sincerely,

Partners HealthCare
Third Party Liability Verification Team
399 Revolution Drive, Suite 520
Somerville, MA 02145-1462
Hours: Monday-Friday: 8:00 AM to 4:00 PM

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