ALBANY MED Health System

No-Fault Accident Request for Information

In No-Fault accidents, we require the insurance information of the vehicle you were in when the accident occurred, or a copy of the police report if you were a pedestrian.

Please provide the information below:

Name of Employee:	
Telephone Number:	
Claim/File Number:	
Date of Accident: (Month, Day, Year)	
Body Part Injured:	

Name of Insurance:	
Insurance Company Street Address:	
City, State, ZIP:	
Telephone Number:	
Policy Number:	
Policy Holder Name:	
Adjuster Name:	
Adjuster Phone Number:	
Effective Date of Policy: (Month, Day, Year)	
Expiration Date of Policy: (Month, Day, Year)	
Any additional insurance(s) the patient may have:	