

St. Lawrence-Lewis Insurances
P.O. Box 300
Richville, NY 13681
(315) 287-2028

Patient Name: _____

Policy Number: _____

In order to properly review the claim for: _____

Provider: LANCE MYLER, D.C. Date of Service: _____

Please complete the following:

Nature of above visit: _____

Date of incident _____ Time of incident _____ am/pm

Where did incident occur? (home, work, other) _____

How did this incident occur? Please provide details: _____

Was this incident related in any way to your work? Yes | No

If yes, please explain: _____

Was this incident the result of a third party? Yes | No

If yes, name and address of third party _____

Do you plan to file a suit against the third party or submit the
medical expenses to the third party's insurance? (such as homeowners, etc.) Yes | No

If yes, when? _____

Signature/Date

Please submit the requested information within thirty days. Upon receipt of the requested information your claim will be processed in accordance to the health plan guidelines. Failure to submit all information will result in the filing of your claim.

Sincerely,
St. Lawrence-Lewis Insurances