MVA FORM - COVERPAGE

We look forward to your upcoming MVA Visit at Desai Medical Center

Please complete and submit the MVA Form before your visit.

This will help expedite your appointment and reduce physical interactions at the office.

PDF PAGE #	FORM TYPE	NOTES/INSTRUCTIONS Do not leave any blank responses – put "None" or "N/A"
1	Coverpage	• Outline and instructions for Physical Forms
2	MVA Form	• Fill out the entire form • If you have a Claim Approval Letter from the MVA insurance, please submit a copy of the letter

Forms should be filled out electronically

- Use *Adobe Reader*
  - Open the PDF in Adobe Reader
  - Go to *Tools*
  - Select *Fill & Sign*
- After you complete your forms, make sure to add your name (LAST, First) in the file name when you *Save*

If you do not have Adobe Reader, download it for free, https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html

Forms should be submitted electronically

- Use *MedTunnel*
  - Log in to MedTunnel with your ID and PW
  - Click *Compose Message*
  - In the *To* field – Enter our MedTunnel ID, DesaiMedicalCenter
    - If it says "No matches found" – ignore it
  - In the *Message* field – Type any message you want to send
  - In the *Attachments* section – Drag and drop the files you want to send
  - Click *Send*

If you do not have a MedTunnel ID, sign up for free, https://server.medtunnel.com/SignUp.aspx#form1

Desai Medical Center
MVA Accident Form

In order to file your visit(s) to an MVA insurance, ALL fields must be completed. Please write legibly.

Last Name: _____ **First Name:** _____

DOB: _____ **SSN:** _____

Contact #: _____ **Home / Mobile / Work**

Email: _____@_____

Date/time of Incident: _____ **City/State of Incident:** _____

I was the: ☐ Driver ☐ Passenger **I was seated in the:** ☐ Front ☐ Back ☐ Left ☐ Right

Injured Body Parts: _____

Did police arrive on scene? ☐ Yes ☐ No

Police Officer: _____ **Badge #:** _____ **Case #:** _____

Prior Healthcare Visits? ☐ Yes ☐ No **Where:** _____ **When:** _____

If you have received a Claim Approval Letter from the MVA insurance, please provide a copy with this form.

Personal Injury Protection (PIP) Carrier: _____

Policy #: _____ **The policy owner is** ☐ Myself ☐ The other vehicle's driver

Has a Claim has been filed to the MVA Insurance? ☐ Yes ☐ No

Approved Claim #: _____ **Approved Body parts**: _____

Agent's Name: _____ **Agent's Phone #:** _____

Claims Address: _____

Attorney's Name: _____ **Case #:** _____

Attorney's Phone #: _____ **Attorney's Fax #:** _____

- I understand that Desai Medical Center will file my visit(s) to my health insurance if this form is incomplete or I do not provide the necessary claim-filing information for the MVA Insurance.
- I understand that MVA coverage is dependent on the PIP benefits available at the time of claim-filing.
- I understand that I am financially responsible for any unpaid charges, regardless of insurance or third-party coverage.

_____ _____

Signature Date

_____ _____

Print Date