AcePhysio

2 Carlton St, Suite 601
Toronto, ON
M5B 1J3
416-900-6653
416-900-1064
info@acephysio.ca
http://www.acephysio.ca

Motor Vehicle Accident (MVA) Pre-Assessment Form

At Ace Physio we understand that a motor vehicle accident insurance claim can feel tiring and tedious to fill out all the paper work. We have created a process to help simplify and expedite the administration. Please help us by completing the following form, and remember we are here to help if you have any questions or require assistance.

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Email: _____

MOTOR VEHICLE INSURANCE INFO:

Claim # _____

Policy Number # _____

Date of Accident # _____

Insurance Company _____

Adjuster Name _____

Adjuster Telephone _____

Adjuster Fax _____

Adjuster Email _____

Have you been contacted by an insurance adjuster or company representative regarding this claim?

□ Yes □ No

Have you completed and sent in an OCF 1 form (Application for Benefits) to your insurance company?

□ Yes □ No

Have you received therapy from a previous clinic for this current insurance claim?

□ Yes □ No

If yes, how long did you attend for? _____
Approximately how many therapy sessions did you attend? _____

Were you ever denied treatment through your Motor Vehicle Accident insurance?

□ Yes □ No

LAWYER INFORMATION:

Do you have a lawyer that had advised you in this case? □ Yes □ No

(if yes, please provide information below)

Name of Company: _____
Name of Lawyer/Paralegal: _____

Address: _____

_____

Telephone: _____

Email: _____

EXTENDED HEALTH CARE INSURANCE INFO:

PLEASE NOTE: Under Ontario law your MVA claim must go through your Extended Health Coverage (EHC) first. Once your Extended Health Coverage has been exhausted then your auto insurer will begin the role of the claim processor.

Does you or your spouse currently have Extended Health Care Insurance?

No ☐ Yes (Please fill in below) ☐

Primary Insurance Company: _____

Policy/Group#: _____ Member ID/Certificate No.: _____

Policy Holder's Name: _____ Policy Holder's DOB: ___/___/ ___ (DD/MM/YY)

Secondary Insurance Company: _____

Policy/Group#: _____ Member ID/Certificate No.: _____

Policy Holder's Name: _____ Policy Holder's DOB: ___/___/ ___ (DD/MM/YY)

I am covered under only one insurance policy ____ Signature _____

I am covered under a secondary insurance policy ____ Signature_____

I, _____ hereby I hereby certify that all the above information is true and correct to the best of my knowledge and belief. Signature: _____ Date: _____