ACTION CHIROPRACTIC CLINIC & THERAPY, PLC
17040 ROBBINS ROAD
GRAND HAVEN, MI 49417
(616) 846-6300 Fax: (616) 846-2197

WORKERS COMPENSATION – AUTO INSURANCE INFORMATION FORM

Patients Name: ____

Address: ____

Date of Birth: ____

Social Security Number: ____

Insurance Company: ____

Billing Address: ____

____

Billing Telephone: ____

Billing Fax Number: ____

Claim Number: ____

Claims Adjuster or
Contact Name: Phone Number with Extension: ______________________________

Please completed the requested information and return to our office by your next visit.

If we do not have this information by the above date, payment for services will be
Considered your responsibility.