Workman's Compensation/Motor Vehicle Accident Form

Patient Information

Patient Name_____ Date of Birth_____

Phone Number_____ Claim Number_____

Insurance Information

Please indicate the type of claim below

- Workman's Compensation
- Motor Vehicle Accident

Name of Insurance Company_____

Address_____ City_____

State_____ Zip _____

Adjustor Contact Number_____ Ext_____

Fax Number_____

Date of Injury_____

Please describe injury (including area(s) affected_____

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*If claim is due to Motor Vehicle Accident please indicate which insurance is primary

- Motor Vehicle
- Health Insurance

Please return this form and direct any questions to:
Meka Spicer/Billing Department
Grand Valley Medical Specialists
1000 East Paris Ave S.E. Suite 100
Grand Rapids, Mi 49546
616-459-3158 ext 239
Fax # 616-988-0071

****Please note prior approval is required by your employer to be seen here for a Workers' Compensation Injury.**