McLaren
HEALTH CARE

Auto/Worker Compensation Pending Information Request Letter

Dear Patient / Guarantor: _____

Account/FIN Number: _____

Our records indicate that the services provided on _____ are related to an auto accident or worker compensation injury. You were unable to provide our Registration Department with your auto insurance or worker compensation information at the time of service, which is needed to appropriately bill your auto insurance or worker compensation carrier.
Please provide us with your insurance information below. You can either call our Registration Department at 810-989-3112 or return this form to us in the envelope provided. It is important that we receive this information in a timely manner. If we do not hear from you, we will bill you directly for the services provided until we have received your auto insurance information.

Auto or Worker Compensation Insurance Name: _____

Auto or Worker Compensation Policy Number: _____

Claim Number: _____

Adjuster Name & Contact Phone Number (if applicable): _____

_____

If you are encountering difficulties meeting your financial responsibility, please inquire about our Financial Assistance program by contacting (586)-710-8300.

Thank you for choosing McLaren Healthcare for your needs. We look forward to serving you now and in the future.

Sincerely,

McLaren Healthcare