

**Absolute Balance Bodywork LLC, NPI #1538451224**

833 SE Main Street #428, Portland, OR 97015

[www.AbsoluteBalanceBodywork.com](http://www.AbsoluteBalanceBodywork.com)

Phone: (504) 477-2857

**Motor Vehicle Accident Claim – Insurance Information**

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street City State Zip

Date of Accident: \_\_\_\_\_ State of Accident \_\_\_\_\_

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip

Insured's Date of Birth: \_\_\_\_\_ Client's Relationship to Insured: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
Street City State Zip

Claims Representative's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip

Insured's Date of Birth: \_\_\_\_\_ Client's Relationship to Insured: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
Street City State Zip

Claims Representative's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER THAT RENDERED SERVICES.

Client Name \_\_\_\_\_ Client Signature \_\_\_\_\_ Date \_\_\_\_\_