

McLaren Print System Order

Order No: 60055 Reprint Previous Order No: 6552
 Order Date: 2021-02-01
 User: Cindy Simpson
 Phone: 8104960900

Ship Location: **MCLAREN OCCUPATIONAL AND CONVENIENT CARE ATTN CINDY**
 2313 East Hill Road
 Grand Blanc, MI 48439

Forms

Quantity: 2500
 Paragon Dept No: 64100
 Dept Name: McLaren Occupational and Convenient Care
 Company Number: 810

Order Total Price: 75.50

Item Number: WC-117H
 Item Description: Providers Report of Claim and Request for Medical Payment
 Revision Date: 1/2012
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info:

PROVIDER'S REPORT OF CLAIM & REQUEST FOR MEDICAL PAYMENT
 Michigan Department of Licensing and Regulatory Affairs
 Workers' Compensation Agency

I. EMPLOYER TO COMPLETE THIS SECTION

Employer Name (Last, First, MI)		Employer Address
Employer Name		City/State
NA	State	Zip Code
Employer Name	Employer's Name	
Employer Address	Employer's Address	
NA	State	Zip Code
Provide the date of injury and date of last medical treatment		
Date of Injury		Date of Last Medical Treatment
Have you given leave to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are there medical in your possession? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Signature		Date of this report

Warning: Failure to furnish information to the purpose of obtaining or denying benefits may result in a criminal or civil prosecution, a civil and/or criminal penalty.

II. PROVIDER TO COMPLETE THIS SECTION

Health Care Provider Name	Provider's Name
Address	Provider's Home/Office Address
NA	State
Zip Code	City/State
Provider Signature	Date of this report

This form is to be submitted to the workers' compensation insurance carrier, self-insured employer or group fund
DO NOT MAIL THIS FORM TO THE WORKERS' COMPENSATION AGENCY