

McLaren Print System Order

Order No: 60121 Reprint Previous Order No: 6552
 Order Date: 2021-02-03
 User: Judy Rife
 Phone: 9892695152

Ship Location: 1040 S Van Dyke Rd
 Bad Axe
 MI, 48413

Forms

Quantity: 1000
 Paragon Dept No: 55276
 Dept Name: Bad Axe Conveninet Care Clinic
 Company Number: 810

Order Total Price: 0.00

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) | | Worker's Injury Number |
| Employer Address | | City/Town |
| State | Zip | Employer Telephone Number |
| Employer Name | | Employer's Name |
| Employer Address | | Employer Telephone Number |
| State | Zip | |
| 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 leave benefits in your contract? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, date of return | | If yes, date needed |
| Employer Signature | | Signature of Employer |

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

II. PROVIDER TO COMPLETE THIS SECTION

| | | |
|---------------------------|-----|--|
| Health Care Provider Name | | Insurance Number |
| Address | | Employer's Representative Address Number |
| State | Zip | Employer's Representative Address Number |
| Provider Signature | | Employer's Representative's Signature Number |

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