

McLaren Print System Order

Order No: 61034 Reprint Previous Order No: 6552
 Order Date: 2021-03-16
 User: Theda Simmonds
 Phone: 989-393-2857

Ship Location: McLaren Occupational and Convenient Care - Bay City Occ
 4 Columbus Ave Ste 140
 Bay City, MI 48708

Forms

Quantity: 1000
 Paragon Dept No: 56052
 Dept Name: Occupational Convenient Care
 Company Number: 989

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		State of MI
City	State	Zip Code
Employer Name	Employer's Telephone Number	
Employer Address	Employer's Fax Number	
City	State	Zip Code
Provide the date of injury and date of first treatment		
Date of Injury		Date of First Treatment
Have you given leave to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are there medical records 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 will result in a criminal or civil prosecution in state and federal courts.

II. PROVIDER TO COMPLETE THIS SECTION

Health Care Provider Name		Insurance Number
Address		Employer's Representative Address Number
City	State	Zip Code
Provider Signature	Date	Employer's Representative's Signature

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