

McLaren Print System Order

Order No: 61896 Reprint Previous Order No: 6552
 Order Date: 2021-04-23
 User: Christy Racignol
 Phone: 2313482828

Ship Location: NMMC North
 116 W Mitchell
 Petoskey, MI 49770

Forms

Quantity: 500
 Paragon Dept No: 50724
 Dept Name: NMMC
 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	City/Town
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 Title

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		Provider's Representative Address Number
State	Zip	Provider's Representative Address Number
Provider Signature		Health Care Provider's Title/Name

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