

McLaren Print System Order

Order No: 62470 Reprint Previous Order No: 6552
Order Date: 2021-05-18
User: Christy Racignol
Phone: 2313482828

Ship Location: NMMC Boyne City
1249 M 75 S
Boyne City , MI 49713

Forms

Quantity: 100
Paragon Dept No: 50726
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)		Employer Address
Employer Name		City/Town
NA	State	Zip Code
Employer Name	Employer Telephone Number	
Employer Name	Employer Fax Number	
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 leave benefits in your contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of return		If yes, date needed
Employer Signature		Employer Title

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		Provider Name
Address		Provider's Representative Address Number
NA	State	Zip Code
Provider Address	NA	Provider's Representative Telephone 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