

**McLaren Print System Order**

Order No: 62763 Reprint Previous Order No: 6552  
 Order Date: 2021-06-02  
 User: Kelly Lewis  
 Phone: 231-348-2828

Ship Location: Northern Michigan MedCenter Petoskey North  
 1890 US 131 Unit 4  
 Petoskey, MI 49770

**Forms**

Quantity: 1000  
 Paragon Dept No: 50724  
 Dept Name: Petoskey North  
 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 received
Employer Signature		Signature of the 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		Signature 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**