

McLaren Print System Order

Order No: 62764 Reprint Previous Order No: 6552
Order Date: 2021-06-02
User: Kelly Lewis
Phone: 231-487-2000

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

Forms

Quantity: 1000
Paragon Dept No: 50722
Dept Name: Petoskey South
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/State
NA	State	Zip Code
Employer Name	Employer Telephone Number	Employer's Name
Employer Address	Employer Telephone Number	
NA	State	Zip Code
Provide the date of injury and date of first medical treatment		
Date of Injury		
Date of First Medical Treatment		
Have you given leave to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are there medical services needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Signature		Signature of Provider

Warning: Failure to furnish information to the provider of attending or attending benefits may result in a denial of your compensation claim and denial of benefits.

II. PROVIDER TO COMPLETE THIS SECTION

Provider Name	Provider Address
City/State	Provider Telephone Number
NA	State
Provider Address	NA
City/State	Provider 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