

McLaren Print System Order

Order No: 63873 Reprint Previous Order No: 6552
 Order Date: 2021-07-27
 User: Jody Terwilliger
 Phone: 8106677040

Ship Location: Lapeer Occ Health
 1181 S Lapeer Rd
 Lapeer, mi 48446

Forms

Quantity: 500
 Paragon Dept No: 65100
 Dept Name: Lapeer Occ Health
 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's Name	Employer's Address
Employer Name	Employer's Address	Employer's City/State
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 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		Provider Address
Address		City/State
NA	State	Zip Code
Provider Signature	NA	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