

**McLaren Print System Order**

**Order No: 8756 Reprint Previous Order No: 6552**  
**Order Date: 2015-02-05**  
**User: Billie Peters**  
**Phone: 810-667-7025**

**Ship Location: McLaren Occupational and Convenient Care**  
**1254 N Main St**  
**Lapeer MI 48446,**

**Forms**

**Quantity: 100**  
**Paragon Dept No: 65100**  
**Dept Name: Lapeer Occupational**  
**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: 1/2004**  
**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 Labor & Economic Growth  
 Workers' Compensation Agency

**1. EMPLOYER TO COMPLETE THIS SECTION**

Employer Name		Employer Address	
City		State	
Zip		Employer Telephone Number	
Employer Name		Employer Telephone Number	
City		Employer Telephone Number	
State		Employer Telephone Number	
Zip		Employer Telephone Number	
Describe the nature of the injury and the date and time of the injury.			
Date of Injury		Date of Report	
Have you paid benefits to date? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has your employee's claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of report		If yes, date received	
Employer Signature		Employer Name	

**2. PROVIDER TO COMPLETE THIS SECTION**

Provider Name		Provider Address	
City		State	
Zip		Provider Telephone Number	
Provider Signature		Date of Report of Injury	

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**