

McLaren Print System Order

Order No: 42607 Reprint Previous Order No: 6552
Order Date: 2019-02-05
User: Jessica Smith
Phone: 989-773-1166

Ship Location: McLaren Central ReadyCare/ attn: Jessica
1523 S. Mission St.
Mt. Pleasant , Mi 48858

Forms

Quantity: 1000
Paragon Dept No: 75400
Dept Name: Central ReadyCare
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 Policy Number
Employer Address		City/Town
State	Zip	Employer's Telephone Number
Employer Name		Employer's Name
Employer Address		Employer's 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 provided a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are copy needed in your possession? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Signature		Date of this report

Make a true and correct statement to the purpose of obtaining or denying benefits and based on a review of your possession of facts and other information.

II. PROVIDER TO COMPLETE THIS SECTION

Identify Provider Name		Provider Number
Address		Provider's Representative Address Number
State	Zip	Provider's Representative Address Number
Provider Signature		Date of this report

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