

McLaren Print System Order

Order No: 50535 Reprint Previous Order No: 6552
 Order Date: 2019-11-22
 User: Shannon Pierce
 Phone: 8104960900

Ship Location: Grand Blanc Occupational and Convenient Care
 2313 E Hill Rd
 Grand Blanc, MI 48439

Forms

Quantity: 1000
 Paragon Dept No: 64100
 Dept Name: Grand Blanc Occupational and Convenient Care
 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 first treatment		
Date of Injury		Date of First Treatment
Have you given leave to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are leave records in your possession? <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 in state and federal courts.

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