

McLaren Print System Order

Order No: 8921 Reprint Previous Order No: 6552
Order Date: 2015-02-11
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 Name	
Employer Name		Employer Telephone Number	
City		State	
Zip		Employer Telephone Number	
Date of Injury: _____ Date of Onset: _____ Date of Last Day of Work: _____ Date of Last Day of Compensation: _____ Date of Return to Work: _____ Date of Last Day of Medical Treatment: _____ Date of Settlement: _____ Date of Last Day of Compensation: _____			

2. PROVIDER TO COMPLETE THIS SECTION

Provider Name		Provider Address	
City		State	
Zip		Provider Telephone Number	
Provider Name		Provider Name	
Provider Name		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