

McLaren Print System Order

Order No: 53818 Reprint Previous Order No: 6552
 Order Date: 2020-04-09
 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)		Employer Address
Employer Name		City/State
NA	State	Zip Code
Employer Name	Employer's Name	
Employer Address	Employer's Address	
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
Employer Signature		Date of this report

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's Name
Address	Provider's Home/Office Address
NA	State
Zip Code	City/State/Zip Code
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