

McLaren Print System Order

Order No: 9255 Reprint Previous Order No: 6552
Order Date: 2015-02-23
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	
Employer Phone		Employer City/State/Zip	
NA	State	City/Town	Employer Telephone Number
Employer Name	Employer Address		
Employer Phone	Employer City/State/Zip		
NA	State	City/Town	
Date of Injury			
Date of Injury		Date of Injury	
If you are not an employer, check <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		If you are not an employer, check <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Employer Signature	Employer Title		

2. PROVIDER TO COMPLETE THIS SECTION

Provider Name		Provider Address	
Provider Phone		Provider City/State/Zip	
NA	State	City/Town	Provider Telephone Number
Provider Name	Provider Address		
Provider Phone	Provider City/State/Zip		
NA	State	City/Town	

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