

McLaren Print System Order

Order No: 9718 Reprint Previous Order No: 6552
Order Date: 2015-03-11
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	County	Employer Telephone Number	Employer Fax Number
Employer Name	Employer Address	Employer Telephone Number	Employer Fax Number
City	State	County	Zip
Date of Injury: _____ Date of Onset of Disability: _____ Date of Last Day of Work: _____ Date of Last Day of Compensation: _____			
How long has your employee been employed by you? <input type="checkbox"/> 1 year <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-20 years <input type="checkbox"/> 21-30 years <input type="checkbox"/> 31-40 years <input type="checkbox"/> 41-50 years <input type="checkbox"/> 51-60 years <input type="checkbox"/> 61-70 years <input type="checkbox"/> 71-80 years <input type="checkbox"/> 81-90 years <input type="checkbox"/> 91-100 years	How long has your employee been employed by you? <input type="checkbox"/> 1 year <input type="checkbox"/> 2-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-20 years <input type="checkbox"/> 21-30 years <input type="checkbox"/> 31-40 years <input type="checkbox"/> 41-50 years <input type="checkbox"/> 51-60 years <input type="checkbox"/> 61-70 years <input type="checkbox"/> 71-80 years <input type="checkbox"/> 81-90 years <input type="checkbox"/> 91-100 years	If you are self-employed, please check this box <input type="checkbox"/>	If you are self-employed, please check this box <input type="checkbox"/>
Employer Signature	Employer Title	Employer Signature	Employer Title

2. PROVIDER TO COMPLETE THIS SECTION

Provider Name	Provider Address
City	State
Zip	County
Provider Telephone Number	Provider Fax Number
Provider Signature	Provider Title

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