PROVIDER'S REPORT OF CLAIM & REQUEST FOR MEDICAL PAYMENT

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency

1. EMPLOYEE TO COMPLETE THIS SECTION

Employee Name (Last, First, MI)			Social Security Number
Employee Address			Date of Birth
City	State	Zip Code	Employee Telephone Number
Employer Name			Supervisor's Name
Employer Address			Employer Telephone Number
City	State	Zip Code	
Describe the type of injury and explain how it happened.			
Date of Injury			Last Day Worked
Have you gone back to work? ☐ Yes ☐ No If yes, date of return			Was injury reported to your employer? ☐ Yes ☐ No If yes, date reported
Employee signature			Date of this report

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

2. PROVIDER TO COMPLETE THIS SECTION

Health Care Provider Name			Telephone Number
Address			Employer's representative authorizing treatment
City	State	Zip Code	Employer's representative's telephone number
Provider signature		Date	Carrier, Self-Insured or Group Fund Name

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' DISABILITYCOMPENSATION AGENCY

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