Claim Information																		Apporti Find
WCB Case #	CC #	Claimant Name	Beneficiary Name	Gender	DOB	DOD	Age	LE	DOA	ANCR	ODNCR	Established Site(s)	Capped Case?	Benefit Cap	MTG In Effect?	Medicare Status	State of Residence	% Indemnity

By submitting this form I hereby certify that this request for reimbursement made to the Chair of the Workers' Compensation Board is true and correct; that no part thereof has been previously paid and the amount stated therein is due and owing.

Insurer ID Number: _____

Insurer FEIN: _____

Insurer Name: _____

_____

Date: _____

Name: _____

Company Name: _____

Title:_____

Telephone Nbr: _____

E-Mail Address: _____

	onment ings	Other Findings		CCP Rate						Reimbursement Period			Total of Period Reimbursement		Total of Other Reimbursement		Credit	
WCB Case #	% Medical	Concurrent Liability	SDF Liability	AWW	Award	Type	Current	14(6)	15(8)	Begin Date	End Date	Weeks	14(6)	15(8)	14(6)	15(8)	14(6)	15(8)

	Total Reimbursement		Projected Life Indemnity		Claim Administration		
WCB Case #	14(6)	15(8)	14(6)	15(8)	Last Alive & Well	Third Party Action	Comments / Explanation Of Projected Life Indemnity Calculation, Other Reimbursement, etc.