

CARRIER'S REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES UNDER SEC. 15-8

WCB CASE NO.	CARRIER CASE NO.	CARRIER ID NO. W	SOC. SEC. NO.
CARRIER'S NAME		CARRIER'S ADDRESS	
CLAIMANT'S NAME			

In support of this request the following statements are submitted:

MEDICAL EXPENSES:

Paid for treatment rendered during period from _____ To _____.
(Receipted bills or photocopies must be attached to original copy.)

TOTAL \$ _____

STATEMENT

I hereby certify that this request for reimbursement made to the Chairman 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.

Signature: _____ Date: _____

Title: _____ Telephone No.: _____

INSTRUCTIONS:

1. Where possible, claim should be submitted for 26 week periods.
2. Forward original and two copies to the local office of the Special Funds Conservation Committee.
3. Retain one copy.

DO NOT USE SPACE BELOW

TO: CHAIRMAN, WORKERS' COMPENSATION BOARD
The Special Funds Conservation Committee approves reimbursement for the above claim totaling \$ _____.
Agreed Date for Medical Reimbursement _____
By _____
Date _____