

APPLICATION FOR REIMBURSEMENT FROM THE MEDICAL BENEFITS FUND

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909

Type or print clearly. Incomplete applications shall be returned.

Employee Name (Last, First, MI)			Social Security Number		
Address (Street Number and Name)			Date of Injury		Date of Birth
City			State		ZIP Code
Employer Name			Insurance Carrier or Service Company		
Address (Street Number and Name)			Address (Street Number and Name)		
City	State	ZIP Code	City	State	ZIP Code
Federal ID Number			NAIC or Self-insurance Number		

Is there a health carrier covering this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please indicate the name of that carrier:					
Please state the reason these bills have not been submitted to the health carrier for payment:					
Period covered by this request					
FROM			THROUGH		
Month	Day	Year	Month	Day	Year
A COPY OF THE MAGISTRATE'S ORDER AND ALL SUBSEQUENT APPELLATE ORDERS MUST ACCOMPANY THIS REQUEST.					
Total Reimbursement Amount Requested					
\$ _____					
A COPY OF ALL ORIGINAL INVOICES (INCLUDING DATE OF SERVICE, NAME OF THE HEALTH CARE PROVIDER AND DIAGNOSIS) AND PROOF OF PAYMENT SHOWING AMOUNT AND DATE PAID MUST BE ATTACHED TO THIS REQUEST.					

***Before you sign this request for reimbursement,
please be sure all attachments are included and the form is complete.***

Name of Authorized Representative (Please print)		Title	Date
Signature of Authorized Representative		Telephone Number (Include area code)	

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act 418.862(2) and R408.32a(3). Completion: Mandatory Penalty: Reimbursement Denied
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