

State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, NJ 08625-0381 WC-381 (3-09)	MEDICAL PROVIDER APPLICATION FOR PAYMENT OR REIMBURSEMENT OF MEDICAL PAYMENT	CASE NO'S.: _____ VICINAGE: _____ <div style="text-align: right;">For Office Use Only</div>
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INJURED WORKER	SOCIAL SECURITY NUMBER:
	NAME:
	ADDRESS:

vs

APPLICANT	FEDERAL EMPLOYER IDENTIFICATION NUMBER:
	NAME:
	ADDRESS:

EMPLOYER	NAME:
	ADDRESS:

ATTORNEY FOR APPLICANT	FEDERAL EMPLOYER IDENTIFICATION NUMBER:
	NAME:
	ADDRESS:
	TELEPHONE NUMBER (AREA CODE):

INSURANCE CARRIER	NAME	<input type="checkbox"/> SELF-INSURED	<input type="checkbox"/> NOT-COVERED
	ADDRESS:		
	CLAIM NUMBER:		

Note: Corporations must be represented by counsel in Workers' Compensation Proceedings

The employee has has not filed a Workers' Compensation Claim Petition related to this injury. **Claim Petition Number :** _____

TO THE DIVISION OF WORKERS' COMPENSATION

Applicant, alleging that the Employee sustained an injury by an accident arising out of and in the course of his / her employment with Respondent, compensable under R.S. 34:15-7 et seq., supplements and amendments, respectfully states:

Date of Accident (If Known):		Date of Last Treatment :	
<input type="checkbox"/> Occupational Exposure	Dates of Exposure:		
History of Accident or Illness:			
Occupation:		Date Stopped Work:	Date Returned to Work:
Sex:	Date of Birth:	Date Injury Reported to Employer and to Whom:	
Diagnosis:			
Date(s) of Treatment	Date Billed	Amount Billed	Amount Paid

What other facts are there that you believe important?

The Applicant therefore requests that the Division of Workers' Compensation determine the amount of payment due from said Respondent, under Revised Statutes of New Jersey, Title 34, Chapter 15, and the acts supplemental thereto and amendatory thereof, and that your Applicant may be awarded costs in this proceeding, and such other or further relief as may be proper.

Applicant

STATE OF NEW JERSEY
COUNTY OF _____
Subscribed and sworn or affirmed to
before me this _____ day of
_____, _____

This Application has been presented by the service provider to the Division of Workers' Compensation for hearing and determination. Unless an Answer is filed within 30 days of the date of service of the Applicant upon you, with the assignment clerk at the vicinage to which the claim is assigned as indicated on the reverse side, and a copy served upon the attorney, **THE APPLICANT WILL PROCEED WITH PROOF OF CLAIM ACCORDING TO LAW AND MAY OBTAIN JUDGMENT AGAINST YOU.**

The Privacy Act, 5 U.S.C. §552a, the Social Security Act, 42 U.S.C. §405, and N.J.S.A. 34:15-1 et seq. authorize the Division of Workers' Compensation to request that the Applicant supply the Division with the employee's Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

DIVISION OF WORKERS' COMPENSATION