A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

REQUEST FOR MEDICAL SERVICES

Date_____

Medical Care Provider: _____

Address:

_____

City_____ State _____ Zip _____

Kindly care for the injury sustained by:

_____on: _____

(Name of Employee) *(Date)*

Description of accident: _____

_____

_____

Name of Employer: _____

Address:_____

Telephone: _____W.C. Policy Number: _____

Requested by: _____

(Signature)

The employee will present this slip to the medical care provider who will attach it to the original bill for services.

PLEASE SEND BILLS DIRECTLY TO:
A.I.M. Mutual Insurance Companies
P.O. Box 4210
Portland, OR 97208

MEDICAL BENEFITS ARE GOVERNED BY THE PROVISIONS OF THE WORKERS COMPENSATION LAW OF THE COMMONWEALTH OF MASSACHUSETTS.

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