MEDICAL MUTUAL®

Workers' Compensation Form

Reset Fields

You received a letter regarding a pending claims investigation. Our investigation of this claim indicates that it may be related to an occupational injury or illness. In order to process the claim with Medical Mutual, please supply the required information below. Please send the completed form to: **MZ: 01-6B-5127, Medical Mutual, PO Box 94611, Cleveland, Ohio, 44101-4611.** Thank you for your response to our claims inquiry.

Patient Information (The first 5 items can be found in the upper right corner of the letter you received.)			
Identification Number	**Claim Number**	**Patient Name**	
Service Date	**Servicing Provider**		
In order to continue processing the above claim, we need your response to the following questions.			
Was this service due to a workplace injury or illness? If you have selected "No" — skip to the last section to fill in your signature, telephone and date.	☐ **Yes**	☐ **No**	
If you have selected "Yes" — please answer the following questions.			
Has a claim been filed, or will a claim be filed, for Workers' Compensation Benefits?	☐ **Yes**	☐ **No**	
Worker's Compensation Claim Number	**Date of Accident**		
Nature of Injury or Illness			
Name of Injured Worker's Employer			
Address of Employer			
City	**State**	**ZIP**	
Signature	**Telephone**	**Date**	

Send completed and signed form to:	**Or fax to:**
MZ: 01-6B-5127 Medical Mutual P.O. Box 94611 Cleveland, Ohio 44101-4611	