PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME:

STREET/P.O. BOX:

CITY, STATE, ZIP:

1. On _____, _____
MONTH DAY Y EAR EMPLOYEE NAME

   experienced a work-related injury while working for _____.
EMPLOYER NAME

2. Describe how the injury occurred:

3. List body part(s) injured:

4. The charges for medical and related services such as prescriptions and mileage in connection with this injury amount to: $_____.
ATTACH COPIES OF ALL BILLS

WHEREFORE, the employee asks the Board to order payment of the attached work-related medical bills and services pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE=S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525