

KENTUCKY DEPARTMENT OF WORKERS CLAIMS

Frankfort, Kentucky 40601

**REQUEST FOR PAYMENT FOR SERVICES OR REIMBURSEMENT
FOR COMPENSABLE EXPENSES**

TO BE FILED WITH THE RESPONSIBLE EMPLOYER OR ITS PAYMENT OBLIGOR

① Name, address and Workers Compensation claim number of Employee for whom services were provided or expenses incurred:

② Specific type and dates of service(s) provided:

Date(s)	Type of Service(s)

③ Name and address of physician who ordered services: (include written authorization if available)

④ Reasonable value of services, including method of computation: \$ _____ : _____

⑤ Other expenses incurred for cure or relief of a work injury or occupational disease(s):

Date	Description of Expense(s)	\$ Amount	If mileage, no. of miles
-----	----- Total	\$:	Miles:

Please attach receipts for all purchased items.

Certification:

I hereby certify that the above services were performed or expenses were incurred for the cure or relief of a work injury or occupational disease sustained by the above employee.

Witness: _____

(Name of Person requesting payment)

Date: _____

Address: _____

Phone no: _____

NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.