State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, NJ 08625-0381

WC-381 r. 8/26/2015

MEDICAL PROVIDER APPLICATION FOR PAYMENT OR REIMBURSEMENT OF MEDICAL PAYMENT

☐ **NEW FILING** ☐ **AMENDED FILING**

CASE NO'S.: _____

VICINAGE: _____

please enter above only if filing an Amended Claim

APPLICANT

TAX IDENTIFICATION NUMBER:

NAME:

ADDRESS:

TELEPHONE NUMBER:

vs

EMPLOYER

NAME:

IF EMPLOYER IS KNOWN BY DIFFERENT NAME, PLEASE INDICATE BELOW:

ADDRESS:

INDICATE THE STATUS OF THE EMPLOYER:

☐ INSURED ☐ UNINSURED ☐ SELF-INSURED (PRIVATE) ☐ SELF-INSURED (GOVT. AGENCY.)

☐ IF UNINSURED, INDIVIDUAL CORPORATE OFFICERS ARE ALSO NAMED AS RESPONDENT(S). SEE SUPPLEMENTAL PAGE FOR DETAILS.

INJURED WORKER

SOCIAL SECURITY NUMBER:

☐ SSN Not Available

NAME:

ADDRESS:

DATE OF BIRTH:

SEX:

ATTORNEY FOR APPLICANT
*** Required if Applicant is a Corporation ***

TAX IDENTIFICATION NUMBER:

NAME:

ADDRESS:

TELEPHONE NUMBER :

FAX NUMBER:

INSURANCE CARRIER

NAME :

ADDRESS:

CARRIER CLAIM NUMBER:

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

The injured worker ☐ has ☐ has not filed a Workers' Compensation Claim Petition related to this injury.

Claim Petition #: _____

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 or Injury(required):	Date of Last Treatment:	☐ Occupational Exposure
Occupation:	Diagnosis:	

History of Accident or Illness:

Date(s) of Treatment:	Date Billed:	Amount Billed:	Amount Paid:
1.			
2.			
3.			
4.			

☐ See attached for additional treatment

What other facts are there that you believe important?

Summary of Changes (*Complete only if filing an Amended pleading*):

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 _____ , 20_____

_____

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.