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Attachments Cover Page

Injured Employee

ID: _____
Last Name: _____
First Name: _____
Date of Birth: _____

WC Claim

Claim Number: _____
Date of Injury: _____

Payer/Carrier

Payer/Carrier Name: _____
Payer/Carrier ID: _____
Adjustor Name: _____

Provider

Provider Name: _____
Provider ID (NPI, TIN): _____

Electronic Bill

Submission Date: _____
Total Charge Amount: _____
Service Date(s): _____
eBill Reference #: _____

This Attachment

Attachment Type: _____
PWK Attachment Reference #: _____

Transmission

Number of pages: _____
Contact Name: _____
Contact Phone: _____
Today's date: _____

Please send the attachments by fax to **800-555-1212** with this cover page. Complete the underlined data elements on this cover page to facilitate the accurate matching of these attachments to the corresponding electronic bill and claim. Send one cover page for the attachments of each bill.