

Insurer _____

Preferred Worker Program Quarterly Claim Cost Reimbursement Request

_____ Quarter _____

Preferred Worker no.	Claim status		Insurer claim no.	Claimant name(s) (Alphabetical order, last, first)	Date of new injury	Date of hire for this job	Qtr/Yr of payment	Claim costs			WCD use only
	Nondis. or Disabling							Disability benefits	Medical benefits	Total costs	
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Totals (Transfer to Page 1):											