

Form 114

KENTUCKY OFFICE OF WORKERS CLAIMS

657 Chamberlin Ave
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 expense incurred: _____

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

<u>Dates:</u>	<u>Type of Service(s)</u>

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):

<u>Dates:</u>	<u>Description of Expense(s)</u>	<u>\$ Amount</u>	<u>If mileage, number of miles</u>
↓		↓	↓
↓		↓	↓
↓		↓	↓
↓		↓	↓
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.