



# LARGE DEDUCTIBLE REPLENISHMENT REQUEST

Claimant: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
Employer \_\_\_\_\_ TPA Claim # \_\_\_\_\_

Reimbursement Period Through \_\_\_\_\_

Total Indemnity Paid to Date \$ \_\_\_\_\_

Total Medical/Rehab/Voc Paid to Date \$ \_\_\_\_\_

Total Expenses Paid to Date\*\* \$ \_\_\_\_\_

**Sub total (a)** \$ \_\_\_\_\_

(Less SIR) - \_\_\_\_\_

(Less SITF/Subro/State Assessments if applicable) - \_\_\_\_\_

(Less Penalties/Interest Paid) - \_\_\_\_\_

(Less Prior MECC reimbursements) - \_\_\_\_\_

**Sub total (b)** - \_\_\_\_\_

**Net reimbursement due (a-b)** \$ \_\_\_\_\_ \*

\*Is this a final reimbursement? YES NO

The following information must be included with the reimbursement request:

- Detailed payment register identifying all indemnity, medical and allocated expense from dollar one. (Include any credits or recoveries)
- If claim has been settled, please include a copy of executed settlement documents
- Summary of paid to date and outstanding reserves by category.

We certify the above amounts are accurate. We are requesting payment on the behalf of the insured, \_\_\_\_\_.

Signed By: \_\_\_\_\_ Company: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Washington Fraud Warning: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

**SEND REQUEST TO:**  
**Midwest Insurance Services**  
**158 Lookout Place, Suite 201**  
**Maitland, FL 32751**  
**(407) 740-5508**

**REV 8-06**