



14755 North Outer Forty Dr.
#300 Chesterfield, MO 63017
636-449-7000
636-449-7199 Fax

Specific Reimbursement Request

REV 08-06

Employee: _____ Date of Accident: _____
MWECC Clm # _____ 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 (insured name)- _____

Unless otherwise requested, payee will be our named insured with the check sent in care of the party requesting the reimbursement. Please supply mailing address. 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."

Signed By: _____ Date: _____

Phone: _____ E-mail: _____

Without the completed information above and the required documents requested, reimbursement will be delayed until received in full.

To help expedite, you may submit this form and documentation described above to ClaimTPA@mwccc.com showing the subject l "REIMBURSEMENT REQUEST"

**Pre 1993 policy Expense will be prorated by MWECC on an ongoing basis.

Copy of this form can be obtained through our website, www.mwecc.com