Bureau of Workers' Compensation

Self-Insured Claims Reimbursement Application

- Please answer all questions. If not applicable, use symbol with N/A.
- Submit completed applications to: BoWC@bwc.state.us or via fax 987-324-1243.

Injured worker	
Injured worker name	Claim number
City/State/Zip	Date of injury
Type of injury (circle one): Occupational Illness Physical Injury Repetitive Stress Injury	

History

Please submit supporting documentation to include all relevant hearing orders (final determination), positive proof of medical benefits (fee bills with ICD-9 codes) and prescription benefits (check copies) and indemnity payments (check copies). Indicate any recoveries as part of the overpayment credit on the *Report of Paid Compensation and Case Reserves* (SI-40). If you have more than one type of indemnity, please submit on additional form.

Signature _____ **Date** _____
(Requestor)