Form 114

KENTUCKY DEPARTMENT OF WORKERS CLAIMS

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 expenses incurred:

_____

_____

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

Date(s)	Type of Service(s)

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):

Date	Description of Expense(s)	$ Amount	If mileage, no. of miles
-------	---------- 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.