Department of Workforce Development
Worker's Compensation Division
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MEDICAL TREATMENT STATEMENT

SUPPLIES AND MEDICATIONS

Complete this form before the prehearing conference (if one is scheduled) and update it before the formal hearing. Bring this form to both the conference and hearing.

NOTE: An itemized statement for each expense claimed must be attached to this form and provided to the Worker's Compensation Division and other parties to this case at least 15 days before the hearing, according to section 102.17(8) of the statutes.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Employee Social Security Number*	Employer Name
Injury Date	Insurance Company Name
Have You Applied For Or Are You Receiving Social Security Benefits? ☐ Yes ☐ No	Have You Applied For Or Are You Covered Under Medicare? ☐ Yes ☐ No If Yes, Medicare Claim Number:

Names of Providers of Treatment, Medication, or Supplies	Total Charges	Amount Paid By Applicant	Amount Paid By Other Insurance Carriers *(Give Carriers' Names)*	Unpaid Balance
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
TOTAL:	$ 0.00	$ 0.00	$ 0.00	$ 0.00