Employee:
Employee ID# :
Claimant Name:
Claimant Acct:
Service Dates:
Total Billed:
Claim:

Dear Provider:

We have recently received charges for the above claimant
as shown above.

In order to consider these charges for payment, we must
have the following information requested below:

1. Was this condition work-related or military service related?
   ____
   ____

2. In your opinion, what is the etiology of this condition?
   ____
   ____
   ____

****
*   *
* Doctor's Signature _______________ Date______________ *
*   *
****

Your cooperation in providing us with this information is
greatly appreciated.

Sincerely,

Claims Department