A.I.M. Mutual
INSURANCE COMPANIES

A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

REQUEST FOR MEDICAL SERVICES

Date______________________________

Medical Care Provider: ____

Address:

____

City_____________________________________ State _____________ Zip ______________

Kindly care for the injury sustained by:

____on: _________________________
(Name of Employee) *(Date)*

Description of accident: ____

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Name of Employer: ____

Address:____

Telephone: ____________________________W.C. Policy Number: ________________________

Requested by: ____
(Signature)

The employee will present this slip to the medical care provider who will attach it to the original bill for services.

PLEASE SEND BILLS DIRECTLY TO:
A.I.M. Mutual Insurance Companies
c/o Corvel Corporation
P.O. Box 3040
Acton, MA 01720

MEDICAL BENEFITS ARE GOVERNED BY THE PROVISIONS OF THE WORKERS COMPENSATION LAW OF THE COMMONWEALTH OF MASSACHUSETTS.
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