



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: _____

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.**