CHECKLIST
MEDICAL CLAIM

CLAIMANT'S NAME _____

ID# _____ **PROFILE ATTACHED** _____

DATE	ACTION TAKEN
	Medical claim form requested by: _____ for: _____ injury: _____ send claim to: _____ _____
	Medical claim form and letter of instructions sent to requested individual. (Copy to Executive Officer) (Copy to CN)
	Claim form returned to Service & Leadership Center.
	Claim form and bills submitted to CNA. (Copy to Executive Officer) (Copy to Lockton Insurance) (Copy to CN)

MED.FRM
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