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STATE OF WYOMING

DEPARTMENT OF WORKFORCE SERVICES
DIVISION OF WORKERS' COMPENSATION
CLAIM FOR NON-MEDICAL SERVICES
307-777-7441

PLEASE PRINT OR TYPE IN BLACK INK

Injured Worker Information

CLAIM # _____

SSN # _____ _____
DATE OF BIRTH

DATE OF INJURY _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Payee Information

FEDERAL TAX ID # OR SOCIAL SECURITY # _____
Required for payment

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # ( ) _____ — _____

DATES OF SERVICE		DESCRIPTION: Please provide a detailed description of services rendered. Also attach any related documents which may clarify, explain, or support the charges being billed.	AMOUNT SUBMITTED
FROM	TO		

I hereby certify under penalty of perjury, that all items billed above were rendered solely on account of the original compensable injury and are true, accurate and complete to the best of my knowledge.

TOTAL

_____ _____
Payee Signature (required) **Date**

INSTRUCTIONS FOR FILING: **Submit billing no later than the 30th of each month for prior month's services or CLAIM MAY BE DENIED**

MAIL ORIGINAL TO: Division of Workers' Compensation
PO Box 20070
Cheyenne, WY 82003-7001