Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Litigated Fax: (608) 260-3053
Telephone: (608) 266-1340
https://dwd.wisconsin.gov/wc

MEDICAL TREATMENT STATEMENT

SUPPLIES AND MEDICATIONS

Complete this form before the prehearing conference (if one is scheduled) and update it before the formal hearing. Bring this form to both the conference and hearing.

NOTE: An itemized statement for each expense claimed must be attached to this form and provided to the Worker's Compensation Division and other parties to this case at least 15 days before the hearing, according to section 102.17(8) of the statutes.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

WC Claim Number	Employee Name
Employee Social Security Number*	Employer Name
Injury Date	Insurance Company Name
Have You Applied For Or Are You Receiving Social Security Benefits? ☐ Yes ☐ No	Have You Applied For Or Are You Covered Under Medicare? ☐ Yes ☐ No If Yes, Medicare Claim Number:

Names of Providers of Treatment, Medication, or Supplies	Total Charges	Amount Paid By Applicant	Amount Paid By Other Insurance Carriers *(Give Carriers' Names)*	Unpaid Balance
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
			Enter Carrier Name Here	$ 0.00
TOTAL:	$ 0.00	$ 0.00	$ 0.00	$ 0.00