som\_currentexporteddate

som\_contactname

address1\_line1

address1\_city, address1\_stateorprovince address1\_postalcode

|  |  |  |  |
| --- | --- | --- | --- |
| Re: Employee ID#: som\_eid | Leave type: | | **Workers’ Compensation** |
|  | |  |  |

Dear fullname:

The Disability Management Office (DMO) was contacted regarding a possible Workers’ Compensation claim. The following information has been provided to assist you with this claim:

*Statewide Occupational Health Clinics*

*Workers’ Compensation Claim Form*

*Authorization for Evaluation*

*WC Summary Sheet*

Submit the *Workers’ Compensation Claim Form* to the DMO:

DMO

P.O. Box 30002

Lansing, Michigan 48909

Fax 517-241-9926

\*Email: [MCSC-DMO@michigan.gov](mailto:MCSC-DMO@michigan.gov)

*\*By choosing to email documentation, you accept the risks that unencrypted messages and any attachments can be intercepted, read, and copied by persons other than the intended recipient.*

The claim will not be filed with Sedgwick\*\* until received.

\*\*Sedgwick is the State of Michigan’s Workers’ Compensation Third Party Administrator (TPA)

If you have any additional questions or require further assistance please contact the DMO   
at 877-443-6362, Option 2.

Sincerely,

owneridname

Disability Management Office

cc: som\_supervisorname, Supervisor