

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RE: Medical Billing

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim #. The claim number will NOT be available for 48 hours.

Dear Medical Provider:

Please be advised that Sedgwick is the Workers Compensation Administrator for the Town of Kernersville whose employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is seeking medical treatment at your facility.

Please send your bills to:

Sedgwick

PO Box 183188

Columbus, OH 43218

Fax: 667.260.5087

If after further review the claim number changes, you will be notified.

Thank you in advance for your attention to this matter.

\*\*\*\*\*\*Please DO NOT bill as SELF PAY\*\*\*\*\*\*

Thank you,

Sedgwick.