

**FORM RQ-02**

**REQUEST TO BECOME A PARTY IN INTEREST**

Instructions: Pursuant to A.S.C.A. §32.0627(g) and §32.0628(a), any group insurance company or health care provider who has made payments on the employee's behalf or provided medical services and wishes to be named a party in interest to obtain reimbursement for those expenses which have been paid, shall file this form, including supporting documentations, with the Commission.

1. <b>Date this Request is Made:</b>		
2. <b>Name of Insurance Group or Medical Provider Making Request:</b>	3. <b>Employee Name</b> (First, Middle, Last):	4. <b>WCC Case No.:</b>
5. <b>Requestor's Contact Information:</b>		
Mailing Address	Telephone:	Fax:
E-mail:		
6. <b>Specify Purpose of Claim:</b>  <input type="checkbox"/> Reimbursement of Expenses Paid  <input type="checkbox"/> Payment of Remaining / Outstanding Expenses	7. <b>Total Reimbursements or Payments being Claimed:</b>	
	Reimbursements (\$):	Remaining   Outstanding Expenses (\$):
8. <b>Notice   Authorization:</b>  I hereby notifying the Commission a total cost of \$_____ in medical services being claimed for reimbursement and/or payment. As the insurance group or medical provider stated herein, I have agreed to provide and furnish all supporting documentations together with the submission of this form to support my claim.		
Name of Person Authorized to Sign Request:	Position or Title of Person Signing:	Signature:
FILED *** AUTHORIZED OWCC PERSONNEL ONLY ***  		