

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE OF INTENT TO BECOME
A PARTY AT INTEREST

Instructions: Any group insurance company or other health care provider who has made payments on the employee's behalf or provided medical services and who wishes to be named a party at interest to obtain reimbursement for those expenses which have been paid, shall file this form with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

A. IDENTIFYING INFORMATION

Employee Name	_____	Soc. Security No.	_____
Address	_____	Date of Injury	_____
	_____	County of Injury	_____

Employer Name	_____		
Address	_____		

Insurer	_____		
Address	_____		

B. NOTICE

Notice is hereby given that:

Name

Address
()

Phone

has made payments or provided medical services in the amount of \$_____ on the employee's behalf for medical treatment, and desires to be made a party at interest in this claim in order to demonstrate that the employer/workers' compensation carrier are responsible for reimbursement for funds so expended, should liability be established under Title 34-9.

C. CERTIFICATION

I hereby certify that I have sent a copy of this form to all parties and counsel in this claim, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

_____ PRINT NAME HERE	_____ SIGNATURE
_____ PHONE	_____ DATE