



WORKERS' COMPENSATION

Insurance identification form

This form identifies SFM as your insurer for the work injury, and gives medical providers information on where to send bills.

Empleado: Este formulario identifica a SFM como su aseguradora para la lesión laboral y les brinda a los proveedores médicos información sobre dónde enviar las facturas.

Entregue este formulario a su proveedor de atención médica.

Employer: Please fill out the information below and give this sheet to your employee to take along on medical visits. Make sure the date of injury matches the date on the First Report of Injury.

Employee: Please give this form to your health care provider.

Cut around dotted line

Fold

SFM <small>The Work Comp Experts</small> Insurance identification information	Send medical bills and records:
Employee: _____ Date of birth: _____ Date of injury: _____ Employer: _____ Policyholder number: _____ Claim number: _____ Employer contact: _____ Contact phone number: _____	<p><input type="checkbox"/> Electronically through Jopari Solutions using payer ID J1553 (Visit jopari.com or call (866) 269-0554 to sign up or learn more)</p> <p><input type="checkbox"/> By mail to SFM Companies P.O. Box 9416 Minneapolis, MN 55440</p> <p>Payment will be provided according to the state's workers' compensation treatment parameters and payment rules for accepted workers' compensation claims. Call SFM for authorization on all surgeries, medical imaging, durable medical equipment and any treatment that departs from the state's treatment guidelines.</p> <p>(800) 937-1181 sfmic.com</p>

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Contact SFM at (952) 838-4200 or (800) 937-1181 or through sfmic.com.