EMPLOYMENT STANDARDS DIVISION
SUMMARY OF SETTLEMENT OF MEDICAL BENEFITS

Form must be completed in full

(1) CLAIMANT:

DATE OF PRIMARY INJURY: INSURER'S PRIMARY CLAIM #:

ADDITIONAL DATE OF INJURY(S) #: ACN #:

INSURER CLAIM(S) # ADDITIONAL ACN #(S):
(Include all Claim #s)

DATE OF MAXIMUM MEDICAL IMPROVEMENT (MMI):

(2) **Copy of last medical report(s) that documents MMI, diagnosis and recommendation for treatment.** (Please attach and list what the attachments are by date and document author.)

(3) **Explanation of rationale used for the closure of medical benefits by settlement. Include the parties' understanding of medical benefits related to the claim(s) being settled** (attach extra page(s) if needed)**.**

Dollar amount of medical benefits included in this settlement $

(4) **The settlement of medical benefits is in the best interest of the parties because**:

Claimant's Explanation needs to be provided on this form: (attach extra page(s) if needed)

Claimant's signature:_____
Acknowledgement of Claimant's Best Interest Statement

Insurer's Explanation needs to be provided on this form: (attach extra page(s) if needed)

(5) **Claimant's Signature**: _____ **Date**:

Witness: **Date**:

Insurer's Signature: _____ **Date**:

(6) **Claimant's Attorney**: **Fee**: $
(Please Print Name) (Do not include costs)

Attorney must provide an explanation of fees applied to the portion of the settlement representing medical benefits obtained due to the efforts of the attorney.

(7) **Reviewed By**: _____ **Date**:
(ESD Examiner)

Questions concerning this form should be addressed to: Employment Standards Division, Workers' Compensation Compliance Bureau, PO Box 8011, Helena, MT 59604-8011, Phone (406) 444-6543