NO-FAULT ATTENDANT CARE CLAIM FORM

Month: _____

DATE 1	DATE 2	DATE 3	DATE 4	DATE 5	DATE 6	DATE 7
DATE 8	**DATE 9**	**DATE 10**	**DATE 11**	**DATE 12**	**DATE 13**	**DATE 14**
DATE 15	**DATE 16**	**DATE 17**	**DATE 18**	**DATE 19**	**DATE 20**	**DATE 21**
DATE 22	**DATE 23**	**DATE 24**	**DATE 25**	**DATE 26**	**DATE 27**	**DATE 28**
DATE 29	**DATE 30**	**DATE 31**				

DATE OF SERVICE: _____ to _____

SERVICE PROVIDER: _____

INJURED PERSON: _____

DESCRIPTION OF SERVICES: _____

_____

_____

_____

_____

RATE: $_____ PER HOUR

TOTAL HOURS: _____

TOTAL CLAIM FOR ATTENDANT CARE FOR MONTH: $_____

I rendered the services described herein. Therefore, I expect that the legal obligation to pay for these services will be honored and that I will be compensated in accordance with the Michigan Law.

Signature: _____ Date: _____