



**Industrial Accidents Division  
Workers' Compensation  
Carrier Contact Form**

Carrier Name: \_\_\_\_\_

FEIN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_

POC EDI Reporting Compliance Contact Person: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

POC Compliance Backup Contact Person: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Claims EDI Reporting Compliance Primary Contact Person: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

**Claims Contact for Public Use**

Claim Administrator: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

**Submitters Information**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Email completed form to: [pocedi@utah.gov](mailto:pocedi@utah.gov)**