



**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