DIVISION OF WORKERS' COMPENSATION

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Jefferson City, MO 65102-0058
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Fax: 573-751-2012
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Email: workerscomp@labor.mo.gov

_____,	)	Medical Fee Dispute No.: ____-_____
Health Care Provider,	)	
vs.	)	Injury No.: ____-_____
_____,	)	
Employer,	)	Employee (Patient): _____
and	)	
_____,	)	Date of Accident/
Insurer	)	Occupational Disease: _____

REQUEST FOR DISMISSAL OF APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES

The undersigned health care provider hereby requests that the Missouri Division of Workers' Compensation dismiss its Application for Payment of Additional Reimbursement of Medical Fees on the following ground:

☐ The medical fee dispute has been resolved or otherwise compromised and settled.
Date: _____ Amount: $_____

☐ The dispute does not involve the type of medical fee dispute applicable to the administrative process involved in the filing of an Application for Payment of Additional Reimbursement of Medical Fees.

☐ The Application for Payment of Additional Reimbursement of Medical Fees was not filed within the limitations period specified in Section 287.140.4, RSMo.

☐ Other: (explain) _____

_____

_____
Health Care Provider

_____
Health Care Provider's Attorney

_____
Address and Phone

_____
Date

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Request for Dismissal of Application for Payment of Additional Reimbursement of Medical Fees has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20_____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP

Missouri Division of Workers' Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.

MISSOURI DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS