MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REQUEST FOR DISMISSAL OF APPLICATION FOR DIRECT PAYMENT

P.O. Box 58
Jefferson City, MO 65102-0058

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

REQUEST FOR DISMISSAL OF APPLICATION FOR DIRECT PAYMENT

The undersigned health care provider hereby requests that the Division of Workers' Compensation of the State of Missouri dismiss its Application for Direct Payment 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 Direct Payment.
- ☐ The health care provided by the undersigned was not authorized by the employer or insurer.

____
Health Care Provider

____
Health Care Provider's Attorney

____
Address and Phone

____
Date

CERTIFICATE OF SERVICE	DIVISION USE ONLY
I, the undersigned, certify that a true and accurate copy of this Request for Dismissal of Application for Direct Payment 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)* ________________________	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. TDD/TTY: 800-735-2966 Relay Missouri: 711