DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

ENTRY OF APPEARANCE

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

_____,
Health Care Provider,

vs.

_____,
Employer,

and

_____,
Insurer

Medical Fee Dispute No: ____-_____

Injury No.: ____-_____

Employee (Patient): _____

Date of Accident/
Occupational Disease: _____

ENTRY OF APPEARANCE

COMES NOW, _____ attorney at law & hereby enters his/her appearance on behalf of:

☐ Health Care Provider

Name _____

☐ Employer

Name _____

☐ Insurer/Third Party Administrator

Name _____

Respectfully submitted, _____

Name of Attorney _____

Law Firm _____

Address _____

Bar No. _____

Phone No. _____

Fax No. _____

Email Address _____

CERTIFICATE OF SERVICE

I, the undersigned, certify that, a copy of this Entry of Appearance 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

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