MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

REQUEST FOR AWARD ON UNDISPUTED FACTS IN REGARD TO APPLICATION FOR DIRECT PAYMENT

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: _____

REQUEST FOR AWARD ON UNDISPUTED FACTS

Employer hereby requests that an Administrative Law Judge of the Division of Workers' Compensation issue an award denying the APPLICATION FOR DIRECT PAYMENT filed herein by _____
(name of health care provider)
on the ground that the health care services for which direct payment is being sought were not authorized by Employer or its Insurer. In support of this request, Employer states that there is no genuine issue of fact necessitating an evidentiary hearing in regard to the APPLICATION FOR DIRECT PAYMENT, and that the following facts are undisputed *(attach additional sheets, if necessary)*:

In support of the undisputed facts listed above, Employer attaches the following exhibits *(attach additional sheets, if necessary)*: Please identify each exhibit by letter "A," "B," etc. and by general description of the document.

_____ _____
Employer/Insurer Signature & Date Employer Address & Phone No.

_____ _____
Employer/Insurer Attorney's Signature & Date Attorney's Address & Phone No.

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Request for Award on Undisputed Facts 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