



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
**HEALTH CARE PROVIDER'S RESPONSE TO  
 REQUEST FOR AWARD ON UNDISPUTED FACTS IN  
 REGARD TO APPLICATION FOR DIRECT PAYMENT**

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

Pursuant to 8 CSR 50-2.030(2)(I)(b) the health care provider shall file its response to the award on undisputed facts within thirty days.

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

**RESPONSE TO REQUEST FOR AWARD ON UNDISPUTED FACTS**

Health Care Provider \_\_\_\_\_ herein, for its response to the  
*(name of health care provider)*  
 REQUEST FOR AWARD ON UNDISPUTED FACTS filed by Employer/Insurer states as follows *(attach additional sheets, if necessary)*:

In support of its statements, Health Care Provider attaches the following exhibits *(attach additional sheets, if necessary)*:  
 Please identify each exhibit by numbers "1," "2," etc. and by general description of the document.

_____	_____
Health Care Provider Signature & Date	Health Care Provider Address & Phone No.
_____	_____
Health Care Provider's Attorney Signature & Date <i>(if applicable)</i>	Attorney's Address & Phone No.

<b>CERTIFICATE OF SERVICE</b>	DIVISION USE ONLY
I, the undersigned, certify that a true and accurate copy of this Response to 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 <i>(Printed)</i> _____ Bar No. _____	
Address <i>(if different than above)</i> _____	
	DATE STAMP