MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

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,)
)
vs.)
)
_____,)
Employer,)
)
and)
)
_____,)
Insurer)

Medical Fee Dispute No: ____-_____

Injury No.: ____-_____

Employee (Patient): _____

Date of Accident/
Occupational Disease: _____

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 *(if applicable)* | Attorney's Address & Phone No.

CERTIFICATE OF SERVICE

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 *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP