DIVISION OF WORKERS' COMPENSATION

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_____,	)	Medical Fee Dispute No.: ____ - _____
Health Care Provider,	)	
vs.	)	Injury No.: ____ - _____
_____,	)	
Employer,	)	Employee (Patient): _____
and	)	
_____,	)	Date of Accident/
Insurer	)	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 PAYMENT OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES filed herein by

_____ on the FOLLOWING GROUNDS:
(name of health care provider)

In support of this request, the employer states that there is no genuine issue of fact necessitating an evidentiary hearing in regard to the APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES, 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 & Telephone No.

_____ _____
Employer/Insurer Attorney's Signature & Date — Attorney's Address & Telephone 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

Missouri Division of Workers' Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.