



- Pursuant to 8 CSR 50-2.030(1)(H) if the total amount of the additional reimbursement sought is one thousand dollars (\$1,000) or less, either party may use this form to file a request for administrative ruling that initiates the administrative ruling procedure.
All parties shall participate in the administrative ruling procedure.

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

APPLICATION FOR ADMINISTRATIVE RULING

Total Amount Disputed \$

The undersigned party hereby applies to the Division of Workers' Compensation for an Administrative Ruling in the above captioned case.

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.
E-mail Address

CERTIFICATE OF SERVICE
I, the undersigned, certify that a true and accurate copy of this Application for Administrative Ruling 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