DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

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

ANSWER TO APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES

☐ Original ☐ Amended

W.C. Injury Number
Medical Fee Dispute No.
Venue

NOTE: Pursuant to 8 CSR 50-2.030 (1) (I), the employer or insurer shall file an answer to the application for an evidentiary hearing within thirty (30) days from the date of the application for an evidentiary hearing, unless good cause is found by the division to extend the filing of the answer.

1. Health Care Provider Name	Mailing Address	City	State	ZIP Code
2. Employee (Patient's) Name	Mailing Address	City	State	ZIP Code
3. Name of Employer	Mailing Address	City	State	ZIP Code
4. Name of Insurer/Third Party Administrator	Mailing Address	City	State	ZIP Code

5. Name of authorized providers of medical aid:	6. Date of Accident/Occupational Disease

7. All of the statements or allegations in the "Application for Payment of Additional Reimbursement of Medical Fees" are admitted except the following: Please describe below each statement or allegation in the "Application for Payment of Additional Reimbursement of Medical Fees" that is being disputed, the reason why it is being disputed and the facts thereto. Please list all affirmative defenses. If needed, attach sheet with additional information.

8. Employer's Signature	Date	9. Insurer's Signature	Date

10. Attorney Signature	Attorney Name *(Type or Print)*	Bar No.	Attorney Email Address

Attorney Mailing Address	City	State	ZIP Code	Attorney Phone No.	Attorney Fax No.

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Answer to Application for Payment of Additional Reimbursement of Medical Fees 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. TDD/TTY: 800-735-2966 Relay Missouri: 711