



**REQUEST BY A HEALTH CARE PROVIDER FOR CASE STATUS  
 INFORMATION TO FILE A MEDICAL FEE DISPUTE APPLICATION**

Note: If you file an "Application for Direct Payment" or an "Application for Payment of Additional Reimbursement of Medical Fees," please return this completed form with your application.

**This form must be completed in its entirety for the Division to evaluate your request. Please state "unknown" if you are unable to complete any required field.**

Health Care Provider Information	
Name & Address	Contact Person Name
	Telephone No.

Employee Information		
Name	Date of Accident/Occupational Disease	Date Service Provided
Social Security No.	Injured Body Part(s)	

Employer Information	
Name	Address

Insurer Information	
Name	Address

**I am requesting the Division to provide the following information (please check all that apply)**

<input type="checkbox"/> Injury No.	<input type="checkbox"/> Insurance Carrier
-------------------------------------	--

<input type="checkbox"/> Status Update	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Report of Injury has been filed with the Division	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Claim for Compensation has been filed with the Division	
c. Date the case was Settled _____	
d. Date the case was Dismissed _____	

<input type="checkbox"/> Name and Address of Claimant's Attorney	<input type="checkbox"/> Name and Address of Employer/Insurer Attorney
--	--

**Please return completed form with a self-addressed stamped envelope to:**

**Missouri Division of Workers' Compensation  
 Attn: Medical Fee Dispute Unit  
 P.O. Box 58  
 Jefferson City, MO 65102-0058**

DIVISION USE ONLY

DATE STAMP