



**REQUEST FOR AWARD ON UNDISPUTED FACTS IN
REGARD TO APPLICATION FOR DIRECT PAYMENT**

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

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 DIRECT PAYMENT filed herein by _____
(name of health care provider)

on the ground that the health care services for which direct payment is being sought were not authorized by Employer or its Insurer. In support of this request, Employer states that there is no genuine issue of fact necessitating an evidentiary hearing in regard to the APPLICATION FOR DIRECT PAYMENT, 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	DIVISION USE ONLY
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 (<i>Printed</i>) _____ Bar No. _____	
Address (<i>if different than above</i>) _____	
	DATE STAMP