



**HEALTH CARE PROVIDER'S RESPONSE TO REQUEST
FOR AWARD ON UNDISPUTED FACTS IN REGARD TO
APPLICATION FOR DIRECT PAYMENT**

Pursuant to 8 CSR 50-2.030(2)(I)(b) the health care provider shall file its response to the award on undisputed facts within thirty days.

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

RESPONSE TO REQUEST FOR AWARD ON UNDISPUTED FACTS

Health Care Provider _____ herein, for its response to the
(name of health care provider)

REQUEST FOR AWARD ON UNDISPUTED FACTS filed by Employer/Insurer states as follows (attach additional sheets, if necessary):

In support of its statements, Health Care Provider attaches the following exhibits (attach additional sheets, if necessary):
Please identify each exhibit by numbers "1," "2," etc. and by general description of the document.

Health Care Provider Signature & Date

Health Care Provider Address & Telephone No.

Health Care Provider's Attorney Signature & Date
(if applicable)

Attorney's Address & Telephone No.

CERTIFICATE OF SERVICE	DIVISION USE ONLY
I, the undersigned, certify that a true and accurate copy of this Response to 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) _____	
	DATE STAMP