



APPLICATION FOR ADMINISTRATIVE RULING

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

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.

<input type="checkbox"/>	Health Care Provider	Name _____
<input type="checkbox"/>	Employer	Name _____
<input type="checkbox"/>	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	DIVISION USE ONLY
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) _____	
* Please be advised that corporations and limited liability companies appearing before the Division must be represented by an attorney licensed in the State of Missouri. See <i>Reed v. Labor and Ind. Rel. Commn.</i>, 789 S.W.2d 19, 20 (Mo. banc 1990).	
* If the Health Care Provider is a corporation or a LLC, and this Application is not signed by an attorney, this Application will be rejected.	DATE STAMP