



**APPLICATION FOR EVIDENTIARY HEARING**

Pursuant to 8 CSR 50-2.030(1)(I), this form shall be used if the total amount of the additional reimbursement sought is more than one thousand dollars (\$1,000), or this form may also be used to request an evidentiary hearing by any party aggrieved by the Division Director's Administrative Ruling, in a case where the additional reimbursement sought was \$1,000 or less.

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

**APPLICATION FOR EVIDENTIARY HEARING**

The undersigned party hereby applies to the Division of Workers' Compensation for an evidentiary hearing in the above captioned case.

- Health Care Provider Name \_\_\_\_\_
- Employer Name \_\_\_\_\_
- Insurer/Third Party Administrator Name \_\_\_\_\_

Respectfully submitted, \_\_\_\_\_  
 Name of Attorney \_\_\_\_\_  
 Law Firm \_\_\_\_\_  
 Address \_\_\_\_\_  
 Bar No. \_\_\_\_\_  
 Phone No. \_\_\_\_\_  
 Fax No. \_\_\_\_\_  
 E-mail Address \_\_\_\_\_

<b>CERTIFICATE OF SERVICE</b>	DIVISION USE ONLY
I, the undersigned, certify that a true and accurate copy of this Application for Evidentiary Hearing 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) _____	
<b>* 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).</b>	
<b>* 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.</b>	DATE STAMP