



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. _____
 Email Address _____

CERTIFICATE OF SERVICE	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) _____	
* 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. Comm.</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