DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

P.O. Box 58
Jefferson City, MO 65102-0058

ANSWER TO APPLICATION FOR DIRECT PAYMENT

☐ Original ☐ Amended

W.C. Injury Number
Medical Fee Dispute No.
Venue

NOTE: No Answer to Application for Direct Payment is required. However, if the Employer/Insurer would like to file an Answer this form should be utilized.

1. Health Care Provider Name	Mailing Address	City	State	ZIP Code
2. Employee (Patient's) Name	Mailing Address	City	State	ZIP Code
3. Name of Employer	Mailing Address	City	State	ZIP Code
4. Name of Insurer/Third Party Administrator	Mailing Address	City	State	ZIP Code

5. Name all authorized providers of medical aid:	6. Date of Accident/Occupational Disease

7. All of the statements or allegations in the "Application for Direct Payment" are admitted except the following: Please describe below each statement or allegation in the "Application for Direct Payment" that is being disputed, the reason why it is being disputed and the facts thereto. Please list all affirmative defenses. If needed, attach sheet with additional information.

8. Employer's Signature	Date	9. Insurer's Signature	Date

10. Attorney Signature	Attorney Name *(Type or Print)*	Bar No.	Attorney Email Address

Attorney Mailing Address	City	State	ZIP Code	Attorney Phone No.	Attorney Fax No.

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Answer to Application for Direct Payment 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)* _____

DIVISION USE ONLY

DATE STAMP

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