



**REQUEST FOR DISMISSAL OF APPLICATION FOR PAYMENT  
OF ADDITIONAL REIMBURSEMENT OF MEDICAL FEES**

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

**REQUEST FOR DISMISSAL OF APPLICATION FOR PAYMENT OF  
ADDITIONAL REIMBURSEMENT OF MEDICAL FEES**

The undersigned party hereby requests the Division of Workers' Compensation to dismiss its Application for Payment of Additional Reimbursement of Medical Fees on the following ground:

- The medical fee dispute has been resolved or otherwise compromised and settled.  
Date \_\_\_\_\_ Amount \_\_\_\_\_
- The dispute does not involve the type of medical fee dispute applicable to the administrative process involved in the filing of an Application for Payment of Additional Reimbursement of Medical Fees.

\_\_\_\_\_  
Health Care Provider

\_\_\_\_\_  
Health Care Provider's Attorney

\_\_\_\_\_  
Address and Telephone

\_\_\_\_\_  
Date

<b>CERTIFICATE OF SERVICE</b>	<b>DIVISION USE ONLY</b>
I, the undersigned, certify that a true and accurate copy of this Request for Dismissal of Application for Payment of Additional Reimbursement of Medical Fees 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