MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

REQUEST FOR DISMISSAL OF APPLICATION FOR DIRECT PAYMENT

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

REQUEST FOR DISMISSAL OF APPLICATION FOR DIRECT PAYMENT

The undersigned party hereby requests the Division of Workers' Compensation to dismiss its Application for Direct Payment 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 Direct Payment.

☐ The health care provided by the undersigned was not authorized by the employer or insurer.

____
Health Care Provider

____
Health Care Provider's Attorney

____
Address and Telephone

____
Date

CERTIFICATE OF SERVICE	DIVISION USE ONLY
I, the undersigned, certify that a true and accurate copy of this Request for Dismissal of 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)* ______________	DATE STAMP