

State of Utah - Labor Commission
Division of Adjudication
160 East 300 South, 3rd Floor, P.O. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800
casefiling@utah.gov
Note: PLEASE TYPE OR PRINT IN BLACK INK

<p>_____</p> <p>Medical Care Provider (Petitioner)</p> <p>_____</p> <p>Injured Employee</p> <p>vs.</p> <p>_____</p> <p>Respondent (employer)</p> <p>_____</p> <p>Respondent's mailing address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>_____</p> <p>Respondent's phone number</p> <p>_____</p> <p>Respondent's worker's comp insurance carrier*</p> <p>_____</p> <p>Insurance Carrier's mailing address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>_____</p> <p>Insurance Carrier's phone number</p>	<p style="text-align: center;">APPLICATION FOR HEARING MEDICAL CARE PROVIDER</p> <p>(NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned)</p> <p>I request to have a Claims Resolution Conference scheduled to resolve the issues checked below</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>*It is the petitioner's obligation to provide the mailing address and phone number for respondent's insurance carrier. If you do not have this information you may obtain this information on the Labor Commission website, Industrial Accidents Division Workers' Compcheck or contact the employer or the Industrial Accidents Division.</p>
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PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. Date of industrial injury: Month ____ Date ____ Year ____.
2. Medical Charges at issue (you must attach an itemized, detailed account of the services rendered, the date of the services, the charges for the services, and the correct RVRBS billing code):
3. Amounts paid by respondents to date: _____.

4. The injuries employee sustained from the accident are: _____

5. If you are billing for restorative services you must include RSA forms.

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.	
Printed Name of Attorney for Petitioner State Bar #	Signature of Petitioner Date
Signature of Attorney for Petitioner	Mailing Address of Petitioner
Mailing Address for Attorney for Petitioner	City/State/Zip Code
City/State/Zip Code (____)	(____)
Telephone Number (____)	Petitioner's Telephone Number
FAX E Mail Address	Petitioner's Social Security Number
	Petitioner's E Mail Address

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim please include that information:

Name of adjuster or third party administrator

Mailing Address for adjuster or third party administrator

City/State/Zip Code