Form 024
6/18/14

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

_____ Medical Care Provider (Petitioner) _____ Injured Employee **vs.** _____ Respondent (employer) _____ Respondent's mailing address _____ City, State and Zip Code _____ Respondent's phone number _____ Respondent's worker's comp insurance carrier***** _____ Insurance Carrier's mailing address _____ City, State and Zip Code _____ Insurance Carrier's phone number	**APPLICATION FOR HEARING** **MEDICAL CARE PROVIDER** (NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned) I request to have a **Claims Resolution Conference** scheduled to resolve the issues checked below ☐ **YES** ☐ **NO** *****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.

PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. Date of industrial injury: Month_____Day___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 Attorney for Petitioner _____ Mailing Address for Attorney for Petitioner _____ City/State/Zip Code (___)_____ Telephone Number (___)_____ FAX E Mail Address	_____ Signature of Petitioner Date _____ Mailing Address of Petitioner _____ City/State/Zip Code (_____)_____ Petitioner's Telephone Number _____ 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