MEDICAL CARE PROVIDER
APPLICATION RESPONSE FORM

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566

Response of: ☐ Employer ☐ Insurer ☐ Other Medical Provider Application filed on (date):

1. The application is: ☐

a. Accepted and paid:

1. In the full amount of $_____on (date)_____
2. With an additional payment of $_____on (date) _____

b. Accepted and payment will be made:

1. In the full amount of $_____on (date)_____
2. With an additional payment of $_____on (date) _____

2. The application is under review for: ☐

a. Repricing _____
b. Negotiation_____
c. Other _____

3. The application is denied: ☐

a. Reason for denial _____
b. This party does ☐ does not ☐ consent to Issue Mediation.

Signature:

**By checking this box and typing my name above, I am electronically signing this form.* ☐