

**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.*