State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, NJ 08625-0381	**RESPONDENT'S ANSWER TO APPLICATION FOR MEDICAL PROVIDER CLAIM PETITION** ANMCP (r. 7/7/10)	**Case No.**: _____ **Vicinage**: _____

INJURED WORKER

SOCIAL SECURITY NUMBER:

NAME:

ADDRESS:

ATTORNEY FOR RESPONDENT

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

NAME:

ADDRESS:

TELEPHONE NUMBER:

FAX NUMBER:

APPLICANT

FEDERAL EMPLOYER IDENTIFICATION NUMBER:

NAME:

ADDRESS:

Vs

RESPONDENT

NAME:

ADDRESS

INSURANCE CARRIER

NAME: ☐ SELF-INSURED ☐ NOT-COVERED

ADDRESS:

CLAIM NUMBER:

IN ANSWER TO MEDICAL PAYMENT APPLICATION, RESPONDENT STATES:

Injured Worker ☐ has ☐ has not filed a Workers' Compensation Claim Petition related to this injury. Claim Petition Number : _____

Is there a contractual rate for reimbursement for this medical provider? YES ☐ NO ☐	
Injured worker was in employment on date alleged in petition: YES ☐ NO ☐	Correct date of accident if incorrect on Application:
Accident arose out of and in the course of employment: YES ☐ NO ☐	Coverage was provided on date of accident or exposure: YES ☐ NO ☐
How and where injury or disease occurred:	
Nature of injury or disease:	
Injured worker's occupation:	Date respondent had knowledge or notice of injury or disease:
Treatment for which payment is sought was authorized: YES ☐ NO ☐ Other pertinent information:	

☐ **See Attached For Additional Information**

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

_____ _____

Attorney for the Respondent **Date**