Before the Iowa Workers' Compensation Commissioner

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	File No(s).: _____ _____ **Answer Concerning Application for Alternate Care**

1. Employer's name is: _____
2. Employer's address is: _____
3. Insurance carrier's name is: _____
4. Insurance carrier's address is: _____
5. Employer: ☐ Admits liability for the claim relating to the following body part(s) or condition(s):

   _____

   ☐ Denies liability for the claim relating to the following body part(s) or condition(s):

   _____
6. A hearing is requested: ☐ By Phone. Call the defendant(s) for the hearing at: _____

   ☐ In person in Des Moines, Iowa.

-or-

_____
Signature of Attorney for Defendant(s)

Name (PIN): _____
Email: _____
Phone: _____
Fax: _____
Address: _____

_____
Signature of Representative of Employer

Name, Title: _____
Email: _____
Phone: _____
Fax: _____
Address: _____

CERTIFICATE OF SERVICE

I, _____,

hereby certify that a copy of this document was served upon counsel of record for each party or each unrepresented party to this case on _____, by:

☐ Iowa Workers' Compensation Electronic System (WCES)

☐ Other: _____

_____ _____

Signature Date

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