BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant(s), vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	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. Defendant(s): ☐ Admit liability for the claim relating to the following body part(s) or condition(s):

   _____

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

   _____
6. Defendant(s) request a hearing: ☐ By phone. Call the defendant(s) for the hearing at: _____

   ☐ In person in Des Moines, Iowa.

_____

Signature of Attorney for Defendant(s) – *or* – Representative of Defendant(s)

Full Name: _____
Law Firm/Entity: _____
Telephone: _____
Email: _____
Mailing Address: _____
_____
_____

CERTIFICATE OF SERVICE

I, _____, hereby certify that a copy of this document was served upon counsel of record for each party or each self-represented party on the date of _____, by:

☐ Iowa Workers' Compensation Electronic System (WCES)

☐ Other: _____

_____ _____

Signature Date

The information provided on this form will be open for public inspection under Iowa Code sections 22.11 and 10A.333(1).