E-Mail to: mgd1009@lwc.la.gov
Fax to: OWCA – Medical Services
ATTN: Medical Director
(225) 342-9836
Mail to: Medical Services
P.O. Box 94040
Baton Rouge, LA 70804

1. Last four digit of Social Security No. _____
2. Date of Injury/Illness _____-_____-_____
3. Parts of Body Injured _____
_____
4. Date of Birth _____-_____- _____
5. Date of This Request _____-_____-_____
6. Claim Number _____

DISPUTED CLAIM FOR MEDICAL TREATMENT

NOTE: THIS REQUEST WILL NOT BE HONORED UNLESS THERE ARE MEDICAL SERVICES IN DISPUTE AS PER R.S. 23:1203.1 J AND THE FOLLOWING HAS OCCURRED:

- **A. The insurer has issued a denial.**
- **B. The insurer has issued an approval with modification.**
- **C. The insurer's failure to act has resulted in a deemed denial.**
- **D. The aggrieved party is seeking a variance from the medical treatment schedule**

DISPUTES RELATING TO COMPENSABILITY AND/OR CAUSATION ARE NOT ADDRESSED BY THE MEDICAL DIRECTOR.

GENERAL INFORMATION
An aggrieved party files this dispute with the Office of Workers' Compensation – Medical Services Director by mail. This office must be notified immediately in writing of changes in address. An employee may be represented by an attorney, but it is not required.

7. This request is submitted by
☐ Employee ☐ Health Care Provider ☐ Other

The following records/documents ***MUST*** be attached to this request. Failure to do so may result in the rejection of the request by the OWCA medical director:

A. Copies of all information must be included with this request as per LAC 40:I.2715 J.
B. If applicable, a copy of the denial letter issued by the insurance carrier **must** be attached to this request.
C. A copy of this request with all supporting documentation must be Faxed or e-mailed to all parties.

EMPLOYEE

8. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone (_____) _____

EMPLOYEE'S ATTORNEY (if any)

9. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone (_____) _____
Fax (_____) _____

EMPLOYER

10. Name _____
Street or Box _____
City _ _____
State _____ Zip _____
Phone (_____) _____
Fax (_____) _____

INSURER/ADMINISTRATOR
(circle one)

11. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone (_____) _____
Fax (_____) _____

TREATING/REQUESTING PHYSICIAN

12. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone (_____) _____
Fax (_____) _____

13. **PLEASE PROVIDE A SUMMARY OF THE DETAILS REGARDING THE ISSUE AT DISPUTE:**

You may attach a letter or petition with additional information with this disputed claim.

By signing below, you are certifying that this form along with all supporting documentation has been sent to the carrier/self-insured employer this date by e-mail or fax.

The information given above is true and correct to the best of my knowledge and belief.

SIGNATURE OF REQUESTING PARTY

DATE

Printed Named of Requesting Party

LWC-WC 1009-Rev 11/2012