Mail To:
LOCAL DISTRICT OFFICE
OR
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
For information call (225) 342-7565
or Toll Free (800) 201-3457.

1. Social Security No. ____-____-____
2. Date of Injury/Illness ____-____-____
3. Part(s) of Body Injured ____
4. Date of This Request ____-____-____
5. Date of Hire ____-____-____
6. Date of Birth ____-____-____

Docket Number

DISPUTED CLAIM FOR COMPENSATION

7. This claim is submitted by:
__ Employee __ Employer __ Insurer __ Dependent __ Health Care Provider __ LDOL __ Other____

GENERAL INFORMATION

Claimant files this dispute with the Office of Workers' Compensation. 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.

EMPLOYEE

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

EMPLOYEE'S ATTORNEY

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

EMPLOYER

10. Name ____
Attn: ____
Street or Box ____
City ____
State ____ Zip ____
Phone ( ) ____

INSURER/ADMINISTRATOR
(circle one)

11. Name ____
Attn: ____
Street or Box ____
City ____
State ____ Zip ____
Phone ( ) ____

EMPLOYER/INSURER'S ATTORNEY
(circle one)

12. Name ____
Attn: ____
Street or Box ____
City ____
State ____ Zip ____
Phone ( ) ____

DEPENDENT/HCP/OTHER
(circle one)

13. Name ____
Relationship ____
Street or Box ____
City ____
State ____ Zip ____
Phone ( ) ____

14. **EMPLOYMENT DATA**

Occupation: ____

Average Weekly Wage $ ____ Workers' Compensation Rate $ ____

15. TO BE COMPLETED BY INJURED EMPLOYEE OR DEPENDENT:

(A) **ACCIDENT DATA**

Date, time and place of accident: _____

_____

Parish of Residence at time of Injury/Illness _____

Accident reported on ____/___/____, to _____ whose position with the employer is_____

Describe the accident and injury in detail (person/equipment involved, type of injury, etc.) _____

_____

_____

_____

List the names, addresses, telephone numbers of any witnesses.

_____

_____

(B) **MEDICAL DATA**

State the names, addresses, and telephone numbers of hospitals, clinics and doctors who have provided medical attention.

_____

_____

_____

(C) **THE BONA-FIDE DISPUTE**

Check the following that apply and fill in the blanks:

__ 1. No wage benefits have been paid

__ 2. No medical treatment has been authorized

__ 3. Occupational Disease

__ 4. Workers' Compensation Rate is Incorrect - Should be $ _____

__ 5. Wage benefits terminated or reduced on _____/_____/_____

__ 6. Medical treatment (Procedure/Prescription) _____

recommended by _____ not authorized.

__ 7. Choice of physician (specialty)_____

__ 8. Disability status_____

__ 9. Vocational Rehabilitation - specify_____

__ 10. Offset/Credit_____

__ 11. Refusal to authorize/submit to evaluation with choice of physician/Independent Medical Examination [L. R. S. 23:1121, 1124(B), or 1317.1(F)]

__ 12. Other: _____

_____

_____

_____

NOTE: You may attach a letter or petition with additional information with this disputed claim or when later amending this disputed claim (Form LDOL-WC-1008). You must provide a copy of this claim and any amendment to all opposing parties.

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

_____ _____

SIGNATURE OF CLAIMANT/ATTORNEY (circle one) DATE