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 (1009)

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, email or fax.** 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/Employee Attorney ☐ Health Care Provider ☐ Other

The completed LWC-WC-1009 must be submitted to OWCA within 15 calendar days of the 1010 denial, 1010 approval w/modification or 1010 deemed denial. 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 Director:

- **A. A copy of the LWC-WC-1010.**
- **B. All of the information previously submitted to the carrier/self-insured employer.**
- **C. Include scientific medical evidence when seeking a variance.**
- **D. If applicable, a copy of the denial letter issued by the insurance carrier.**

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 (_____) _____

HEALTH CARE PROVIDER

12. Name _____
Street or Box _____
City_____
State_____Zip_____
Phone (_____)_____
Fax (_____)_____

EMPLOYER/INSURER ATTORNEY

13. Name _____
Street or Box _____
City_____
State_____Zip _____
Phone (_____) _____
Fax (_____) _____

12. **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 **(Required)** DATE

Printed Named of Requesting Party

LWC-WC 1009-Rev 12/2014