Print Form

RETURN TO:
OFFICE OF WORKERS' COMPENSATION, ATTN: Medical Services
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7559
TOLL FREE (800) 201-2494

1. Social Security No. ____-____-____
2. Date of Injury/Illness ____-____-____
3. Part(s) of Body to be evaluated _____
4. Date of Birth ____-____-____
5. OWC Docket Number _____
6. OWC District Number _____
7. Claim # _____

REQUEST FOR INDEPENDENT MEDICAL EXAMINATION

NOTE: THIS REQUEST WILL NOT BE HONORED
UNLESS A DISPUTE HAS ARISEN AS TO
CONDITION OF THE EMPLOYEE AS PER L.R.S. 23:1123.

8. This form is submitted by:

☐ Employee ☐ Employer ☐ Insurer ☐ TPA/Self Insurance Fund

A. The choice of the medical practitioner shall be that of the Director of the Office of Workers' Compensation as per L.R.S. 23:1123.

B. A cover letter outlining the conflicting medical issue(s) in dispute (reason for request) along with the conflicting medical reports must be attached to this form.

C. A list of names, addresses, phone numbers and reports of all physicians/medical providers who have treated or examined the injured employee for this injury must be included. Indicate who chose each health care provider.

D. A copy of this request must be **signed, dated and mailed** to all parties.

EMPLOYEE

9. Name _____

Street or Box _____

City _____

State _____ Zip _____

Phone ( ) _____

EMPLOYEE'S ATTORNEY

10. Name _____

Street or Box _____

City _____

State _____ Zip _____

Phone ( ) _____

Fax ( ) _____

EMPLOYER

11. Name _____

Street or Box _____

City _____

State _____ Zip _____

Phone ( ) _____

INSURER / ADMINISTRATOR

(circle one)

12. Name _____

Adjuster Name _____

Street or Box _____

City _____

State _____ Zip _____

Phone ( ) _____

Fax ( ) _____

EMPLOYER / INSURER'S ATTORNEY

(circle one)

13. Name _____

Street or Box _____

City _____

State _____ Zip _____

Phone ( ) _____

Fax ( ) _____

_____

Signature of Applicant **Date**

LWC-WC 1015
REVISED 10/14