

**LWC FORM 1010 - REQUEST OF AUTHORIZATION/CARRIER OR SELF INSURED EMPLOYER RESPONSE**

PLEASE PRINT OR TYPE

**SECTION 1. IDENTIFYING INFORMATION - To Be Filled Out By Health Care Provider**

P A T I E N T	Last Name: First: Middle:		Street Address, City, State, Zip:		
	Social Security Number:		Date of Birth:	Phone Number:	Date of Injury:
C A R R I E R	Employers Name:		Street Address, City, State, Zip:		Phone Number:
	Name:		Adjuster:		Claim Number (if known):
Street Address, City, State Zip:		Email Address:	Phone Number:	Fax Number:	

**SECTION 2. REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider**

P R O V I D E R	Requesting Health Care Provider:		Phone Number:	Fax Number:	
	Street Address, City, State Zip:			Email:	
	Diagnosis:		CPT/DRG Code:	ICD-9/DMS-4 Code:	
	Requested Treatment or Testing (Attach Supplement If Needed):				
	Reason for Treatment or Testing (Attach Supplement If Needed):				

**INFORMATION REQUIRED BY RULE TO BE INCLUDED WITH REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider**

(Following is the required minimum information for Request of Authorization (LAC 40:2715 (C))

P R O V I D E R	<input type="checkbox"/> History provided to the level of condition and as provided by Medical Treatment Schedule <input type="checkbox"/> Physical Findings/Clinical Tests <input type="checkbox"/> Documented functional improvements from prior treatment <input type="checkbox"/> Test/imaging results <input type="checkbox"/> Treatment Plan including services being requested along with the frequency and duration				
	I hereby certify that this completed form and above required information was <input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____				
	<input type="checkbox"/> Emailed (day) (month) (year)				
	Signature of Health Care Provider:			Printed Name:	

**SECTION 3. RESPONSE OF CARRIER/SELF INSURED EMPLOYER FOR AUTHORIZATION**

(Check appropriate box below and return to requesting Health Care Provider, Claimant and Claimant Attorney as provided by rule)

C A R R I E R	<input type="checkbox"/> The requested Treatment or Testing is <b>approved</b>				
	<input type="checkbox"/> The requested Treatment or Testing is <b>approved with modifications</b> (Attach summary of reasons and explanation of any modifications)				
	<input type="checkbox"/> The requested Treatment or Testing is <b>denied</b> because				
	<input type="checkbox"/> Not in accordance with Medical Treatment Schedule or R.S.23:1203.1(D) (Attach summary of reasons)				
	<input type="checkbox"/> The request, or a portion thereof, is not related to the on-the-job injury				
	<input type="checkbox"/> The claim is being denied as non-compensable				
	<input type="checkbox"/> Other (Attach brief explanation)				
	I hereby certify that this response of Carrier/Self Insured Employer for Authorization was <input type="checkbox"/> Faxed to the Health Care Provider (and to the Attorney of Claimant if one exists, if denied or approved with modification) on this the _____ day of _____, _____				
	<input type="checkbox"/> Emailed (day) (month) (year)				
	Signature of Carrier/Self Insured Employer or Utilization Review Company:			Printed Name:	

  

C A R R I E R	<input type="checkbox"/> The prior <b>denied</b> or <b>approved with modification</b> request is now <b>approved</b>				
	I hereby certify that this response of Carrier/Self Insured Employer for Authorization was <input type="checkbox"/> Faxed to the Health Care Provider and Attorney of Claimant if one exists on this the _____ day of _____, _____				
	<input type="checkbox"/> Emailed (day) (month) (year)				
Signature of Carrier/Self Insured Employer or Utilization Review Company:			Printed Name:		

**SECTION 4. FIRST REQUEST**

(Form 1010A is required to be filled out by Carrier/Self Insured Employer and Health Care Provider)

C A R R I E R	<input type="checkbox"/> The requested Treatment or Testing is delayed because minimum information required by rule was not provided
	I hereby certify that this First Request and accompanying Form 1010A was <input type="checkbox"/> Faxed to the Health Care Provider on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
	<b>Signature of Carrier/Self Insured Employer or Utilization Review Company:</b>
P R O V I D E R	I hereby certify that a response to the First Request and accompanying Form 1010A was <input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
	<b>Signature of Health Care Provider:</b>
	<b>Printed Name:</b>

**SECTION 5. SUSPENSION OF PRIOR AUTHORIZATION DUE TO LACK OF INFORMATION**

Suspension of Prior Authorization Process due to Lack of Information	
C A R R I E R	<input type="checkbox"/> The requested Treatment or Testing is delayed due to a Suspension of Prior Authorization Due to Lack of Information
	I hereby certify that this Suspension of Prior Authorization was <input type="checkbox"/> Faxed to the Health Care Provider on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
	<b>Signature of Carrier/Self Insured Employer or Utilization Review Company:</b>
Appeal of Suspension to Medical Services Section by Health Care Provider	
P R O V I D E R	I hereby certify that this form and all information previously submitted to Carrier/Self Insured Employer was faxed to OWCA Medical Services (Fax Number: 225-XXX-XXXX) this _____ day of _____, _____.
	I hereby certify that this Appeal of Suspension of Prior Authorization was <input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
	<b>Signature of Health Care Provider:</b>
<b>Printed Name:</b>	

**SECTION 6. DETERMINATION OF MEDICAL SERVICES SECTION**

O W C A	<input type="checkbox"/> The required information of LAC40:2715(C) was <i>not</i> provided
	<input type="checkbox"/> The required information of LAC40:2715(C) was provided
	I hereby certify that a written determination was <input type="checkbox"/> Faxed to the Health Care Provider & Carrier/Self Insured Employer on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
<b>Signature:</b>	<b>Printed Name:</b>

**SECTION 7. HEALTH CARE PROVIDER RESPONSE TO MEDICAL SERVICES DETERMINATION**

P R O V I D E R	I hereby certify that additional information, pursuant to the determination of Medical Services Section, was <input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____ <input type="checkbox"/> Emailed (day) (month) (year)
	<b>Signature of Health Care Provider:</b>
	<b>Printed Name:</b>