**LWC FORM 1010¾REQUEST OF AUTHORIZATION/**
**CARRIER OR SELF INSURED EMPLOYER RESPONSE**
**PLEASE PRINT OR TYPE**

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

| PATIENT | | | | |
|---|---|---|---|---|
| Last Name: First: Middle: | | Street Address, City, State, Zip: | | |
| Last Four Digits of Social Security Number: | Date of Birth: | Phone Number: | Date of Injury: | |
| Employers Name: | | Street Address, City, State, Zip: | | Phone Number: |

| CARRIER | | | |
|---|---|---|---|
| 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 Provi der**

| PROVIDER | | |
|---|---|---|
| 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))

| PROVIDER | |
|---|---|
| ☐ | History provided to the level of condition and as provided by Medical Treatment Schedule |
| ☐ | Physical Findings/Clinical Tests |
| ☐ | Documented functional improvements from prior treatment |
| ☐ | Test/imaging results |
| ☐ | Treatment Plan including services being requested along with the frequency and duration |

**LWC FORM 1010¾ REQUEST OF AUTHORIZATION/**
**CARRIER OR SELF INSURED EMPLOYER RESPONSE**
**PLEASE PRINT OR TYPE**

I hereby certify that this completed form and above required information was

☐ Faxed

☐ Emailed

to the Carrier/Self Insured Employer on this the

_____ day of ______ , ______
(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)

CARRIER

☐ The requested Treatment or Testing is **approved**

☐ The requested Treatment or Testing is **approved with modifications** (Attach summary of reasons and explanation of any modifications)

☐ The requested Treatment or Testing is **denied** because

| | |
|---|---|
| ☐ | Not in accordance with Medical Treatment Schedule or R.S.23:1203.1(D) (Attach summary of reasons) |
| ☐ | The request, or a portion thereof, is not related to the on-the-job injury |
| ☐ | The claim is being denied as non-compensable |
| ☐ | Other (Attach brief explanation) |

**LWC FORM 1010¾REQUEST OF AUTHORIZATION/
CARRIER OR SELF INSURED EMPLOYER RESPONSE
PLEASE PRINT OR TYPE**

I hereby certify that this response of Carrier/Self Insured Employer for Authorization was

☐ Faxed

☐ Emailed

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 ______ , ______
(day) (month) (year)

**Signature of Carrier/Self Insured Employer:**

**Printed Name:**

☐ The prior **denied** or **approved with modification** request is now **approved**

I hereby certify that this response of Carrier/Self Insured Employer for Authorization was

☐ Faxed

☐ Emailed

to the Health Care Provider and Attorney of Claimant if one exists on this the

_____ day of ______ , ______
(day) (month) (year)

**Signature of Carrier/Self Insured Employer:**

**Printed Name:**

**SECTION 4. FIRST REQUEST**

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

CARRIER

☐ 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

☐ Faxed

☐ Emailed

to the Health Care Provider on this the

_____ day of ______ , ______
(day) (month) (year)

**Signature of Carrier/Self Insured Employer:**

**LWC FORM 1010¾ REQUEST OF AUTHORIZATION/**
**CARRIER OR SELF INSURED EMPLOYER RESPONSE**
**PLEASE PRINT OR TYPE**

PROVIDER

| I hereby certify that a response to the First Request and accompanying Form 1010A was | ☐ Faxed<br>☐ Emailed | to the Carrier/Self Insured Employer on this the<br>_____ day of ______ , ______<br>(day) (month) (year) |
|---|---|---|
| **Signature of Health Care Provider:** | | **Printed Name:** |

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

CARRIER

Suspension of Prior Authorization Process due to Lack of Information

☐ 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 | ☐ Faxed<br>☐ Emailed | to the Health Care Provider on this the<br>_____ day of ______ , ______<br>(day) (month) (year) |
|---|---|---|
| **Signature of Carrier/Self Insured Employer:** | | **Printed Name:** |

PROVIDER

Appeal of Suspension to Medical Services Section by Health Care Provider

I hereby certify that this form and all information previously submitted to Carrier/Self Insured Employer was faxed to OWCA Medical Services (Fax Number: 225-342-9836) this _______ day of ______, _________.

| I hereby certify that this Appeal of Suspension of Prior Authorization was | ☐ Faxed<br>☐ Emailed | to the Carrier/Self Insured Employer on this the<br>_____ day of ______ , ______<br>(day) (month) (year) |
|---|---|---|
| **Signature of Health Care Provider:** | | **Printed Name:** |

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

**LWC FORM 1010¾REQUEST OF AUTHORIZATION/**
**CARRIER OR SELF INSURED EMPLOYER RESPONSE**
**PLEASE PRINT OR TYPE**

OWCA

☐ The required information of LAC40:2715(C) *was not* provided

☐ The required information of LAC40:2715(C) *was* provided

| I hereby certify that a written determination was | ☐ Faxed<br>☐ Emailed | to the Health Care Provider & Carrier/Self Insured Employer on this the<br>_____ day of ______ , ______<br>(day) (month) (year) |
|---|---|---|
| **Signature:** | | **Printed Name:** |

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

PROVIDER

| I hereby certify that additional information, pursuant to the determination of Medical Services Section, was | ☐ Faxed<br>☐ Emailed | to the Carrier/Self Insured Employer on this the<br>_____ day of ______ , ______<br>(day) (month) (year) |
|---|---|---|
| **Signature of Health Care Provider:** | | **Printed Name:** |