LWC FORM 1010¾ 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								
PATIENT	Last Name: First: Middle:		Street Address, City, S		State, Zip:			
	Last Four Digits of Social Security Number:	Date of Birt	Birth: Phone Numbe		er:	Date of Injury		
	Employers Name:		Street Address, City, State, Zip		ate, Zip	: Phone Number:		
CARRIER	Name:		Adjuster:			Claim Number (if known):		
ER	Street Address, City, State Zip:		Email Address: Ph		Phone	e Number: Fax Nu		Fax Number:
	SECTION 2. REQUEST	FOR AUTHO	ORIZA	ATION - To Be	e Filled	Out By Hea	lth Car	e Provi der
PRO	Requesting Health Care I	Provider		Phone Number: Fa		Fax Num	Fax Number:	
PROVIDER	Street Address, City, State Zip:				Email:			
	Diagnosis:			CPT/DRG Co	de:	ICD-9/DMS-4 Code:		
	Requested Treatment or Testing (Attach Supplement If Needed):							
INFOR	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	<b>C</b> History pr	History provided to the level of condition and as provided by Medical Treatment Schedule						
ER	Physical F	Physical Findings/Clinical Tests						
	Document	Documented functional improvements from prior treatment						
	Test/imag	Test/imaging results						
	Treatment C.	Treatment Plan including services being requested along with the frequency and duration						

		ER OR SELF INS		JTHORIZATION/ OYER RESPONSE YPE			
	I hereby certify that this co and above required inform	ompleted form		to the Carrier/Self Insured Employer on this the day of,			
			Faxed	(day) (month) (year)			
	Signature of Health Care	Provider:	Emailed	Printed Name:			
SECTION 3. RESPONSE OF CARRIER/SELF INSURED EMPLOYER FOR AUTHORIZATION							
		d return to requesti		Provider, Claimant and Claimant Attorney as			
CARRIER	The requested Treatment or Testing is <b>approved</b>						
	The requested Treatment or Testing is <b>approved with modifications</b> (Attach summary of reasons and explanation of any modifications)						
	The requested Treatment or Testing is <b>denied</b> because						
	Ð	Not in accordance with Medical Treatment Schedule or R.S.23:1203.1(D) (Attach summary of reasons)					
	Ð	The request, or a portion thereof, is not related to the on-the-job injury					
	Ð	The claim is being denied as non-compensable					
	τ	Other (Attach brief explanation)					

	LWC FORM 1010¾ REC CARRIER OR SELF INS	URED EMPL	OYER RESPONSE			
	I hereby certify that this response of Carrier/Self Insured Employer for Authorization was	PRINT OR TY	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)			
		亡 Emailed				
	Signature of Carrier/Self Insured Employer	r:	Printed Name:			
	The prior <b>denied</b> or <b>approved with mod</b>					
	I hereby certify that this response of Carrier/Self Insured Employer for Authorization was	1	to the Health Care Provider and Attorney of Claimant if one exists on this the day of,			
		Faxed	(day) (month) (year)			
		Ð				
	Signature of Carrier/Self Insured Employer	Emailed r:	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		to the Health Care Provider on this the			
	accompanying Form 1010A was	⊐ Faxed	day of, (day) (month) (year)			
		⊐ Emailed				
	Signature of Carrier/Self Insured Employe					
	Signature of Carrier/Sen insureu Employe					

	PLEASE		to the Carrier/Salf Insured Employer on th		
PROVIDER	I hereby certify that a response to the First Request and accompanying Form 1010A was		to the Carrier/Self Insured Employer on th the day of,		
		Faxed	(day) (month) (year)		
		Emailed			
	Signature of Health Care Provider:		Printed Name:		
S	ECTION 5. SUSPENSION OF PRIOR AUT	HORIZATIO	N DUE TO LACK OF INFORMATION		
CARRIER	Suspension of Prior Authorization Process due to Lack of Information				
ER	C: The requested Treatment or Testing is delayed due to a Suspension of Prior Authorization Due to Lagor for Information				
	I hereby certify that this Suspension of Prior Authorization was		to the Health Care Provider on this the		
		⊟ Faxed	day of, (day) (month) (year)		
		Faxed			
	Signature of Carrier/Self Insured Employe	Faxed Emailed	(day) (month) (year)		
	Signature of Carrier/Self Insured Employe	Faxed = Emailed r:	(day) (month) (year) Printed Name:		
PROVIDER		Faxed = Emailed r: dical Services tion previously	(day)       (month)       (year)         Printed Name:       Printed Name:         Section by Health Care Provider         y submitted to Carrier/Self Insured Employer		
PROVIDER	Appeal of Suspension to Me I hereby certify that this form and all informat	Faxed = Emailed r: dical Services tion previously	(day)       (month)       (year)         Printed Name:		
PROVIDER	Appeal of Suspension to Med I hereby certify that this form and all informat was faxed to OWCA Medical Services (Fax 	Faxed = Emailed r: dical Services tion previously Number: 225-	(day)       (month)       (year)         Image: Printed Name:       Image: Printed Name:         Section by Health Care Provider       Image: Printed Name:         y submitted to Carrier/Self Insured Employer       Image: Printed Self Insured Employer         342-9836)       this day of,         to the Carrier/Self Insured Employer on the the       Image: Printed Self Insured Employer		
PROVIDER	Appeal of Suspension to Med I hereby certify that this form and all informat was faxed to OWCA Medical Services (Fax 	Faxed = Emailed r: dical Services tion previously Number: 225-	(day)       (month)       (year)		
PROVIDER	Appeal of Suspension to Med I hereby certify that this form and all informat was faxed to OWCA Medical Services (Fax 	Faxed = Emailed r: dical Services tion previously Number: 225- Faxed	(day)       (month)       (year)		

LWC FORM 1010¾ REQUEST OF AUTHORIZATION/ CARRIER OR SELF INSURED EMPLOYER RESPONSE PLEASE PRINT OR TYPE							
OWCA	The required information of LAC40:2715(C) <i>was not</i> provided						
The required information of LAC40:2715(C) <i>was</i> provided							
	I hereby certify that a written determination was	Ċ	to the Health Care Provider & Carrier/Self Insured Employer on this the day of,				
		Faxed	(day) (month) (year)				
		3					
		Emailed					
	Signature:	Printed Name:					
SEC	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		to the Carrier/Self Insured Employer on this the day of,				
DER		Faxed	(day) (month) (year)				
		1					
	Signature of Health Care Provider:	Emailed	Printed Name:				
	Signature of nearth Care Provider:		rimeu mame:				