Mail To:
LOCAL DISTRICT OFFICE
OR
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
For information call (225) 342-7565
or Toll Free (800) 201-3457.

1. Social Security No. _____-_____-_____

2. Date of Injury/Illness _____-_____-_____

3. Part(s) of Body Injured _____

4. Date of This Request _____-_____-_____

5. Date of Hire _____-_____-_____

6. Date of Birth _____-_____-_____

_____
Docket Number

DISPUTED CLAIM FOR COMPENSATION

7. This claim is submitted by:
☐ Employee ☐ Employer ☐ Insurer ☐ Dependent ☐ Health Care Provider ☐ LDOL ☐ Other_____

GENERAL INFORMATION

Claimant files this dispute with the Office of Workers' Compensation. 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.

EMPLOYEE

8. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYEE'S ATTORNEY

9. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYER

10. Name _____
Attn: _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

INSURER/ADMINISTRATOR
(circle one)

11. Name _____
Attn: _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

EMPLOYER/INSURER'S ATTORNEY
(circle one)

12. Name _____
Attn: _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

DEPENDENT/HCP/OTHER
(circle one)

13. Name _____
Relationship _____
Street or Box _____
City _____
State _____ Zip _____
Phone ( ) _____

14. **EMPLOYMENT DATA**

Occupation: _____

Average Weekly Wage $ _____ Workers' Compensation Rate $ _____

15. TO BE COMPLETED BY INJURED EMPLOYEE OR DEPENDENT:

(A) **ACCIDENT DATA**

Date, time and place of accident: _____

_____

Parish of Residence at time of Injury/Illness _____

Accident reported on ____/___/___, to _____ whose position with the employer is_____

Describe the accident and injury in detail (person/equipment involved, type of injury, etc.) _____

_____

_____

_____

List the names, addresses, telephone numbers of any witnesses.

_____

_____

(B) **MEDICAL DATA**

State the names, addresses, and telephone numbers of hospitals, clinics and doctors who have provided medical attention.

_____

_____

_____

(C) **THE BONA-FIDE DISPUTE**

Check the following that apply and fill in the blanks:

__ 1. No wage benefits have been paid

__ 2. No medical treatment has been authorized

__ 3. Occupational Disease

__ 4. Workers' Compensation Rate is Incorrect - Should be $ _____

__ 5. Wage benefits terminated or reduced on _____/_____/_____

__ 6. Medical treatment (Procedure/Prescription) _____

recommended by _____ not authorized.

__ 7. Choice of physician (specialty)_____

__ 8. Disability status_____

__ 9. Vocational Rehabilitation - specify_____

__ 10. Offset/Credit_____

__ 11. Refusal to authorize/submit to evaluation with choice of physician/Independent Medical Examination [L. R. S. 23:1121, 1124(B), or 1317.1(F)]

__ 12. Other: _____

_____

_____

_____

NOTE: You may attach a letter or petition with additional information with this disputed claim or when later amending this disputed claim (Form LDOL-WC-1008). You must provide a copy of this claim and any amendment to all opposing parties.

The information given above is true and correct to the best of my knowledge and belief.

_____ _____

SIGNATURE OF CLAIMANT/ATTORNEY (circle one) DATE

LDOL-WC-1008
REV. 1/98

COMPLETE BOTH PAGES