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

PATIENT

Last Name:	First:	Middle:	Street Address, City, State, Zip:	
Last 4 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 Provider

PROVIDER

Requesting Health Care Provider:	Phone Number:	Fax Number:
Street Address, City, State Zip:	Email:	
Diagnosis:	CPT/DRG Code:	ICD/DSM 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

I hereby certify that this completed form and above required information was ☐ Faxed ☐ Emailed to the Carrier/Self Insured Employer on this the ____ (day) day of ____ (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)

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) day of ____ (month), ____ (year)

Signature of Carrier/Self Insured Employer or Utilization Review Company: **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) day of ____ (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)

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 or Utilization Review Company:

PROVIDER

I hereby certify that a response to the First Request and accompanying Form 1010A 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 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 ☐ Emailed to the Health Care Provider on this the _____ day of _____ , _____ (day) (month) (year)

Signature of Carrier/Self Insured Employer or Utilization Review Company: | **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 ☐ Emailed to the Carrier/Self Insured Employer on this the _____ day of _____ , _____ (day) (month) (year)

Signature of Health Care Provider: | **Printed Name:**

SECTION 6. DETERMINATION OF MEDICAL SERVICES SECTION

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 ☐ Emailed to the Health Care Provider & Carrier/Self Insured Employer on this the _____ day of _____ , _____ (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 ☐ Emailed to the Carrier/Self Insured Employer on this the _____ day of _____ , _____ (day) (month) (year)

Signature of Health Care Provider: | **Printed Name:**