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.

____
Docket Number

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 ______-______-______

DISPUTED CLAIM FOR COMPENSATION

7. This claim is submitted by:
__ Employee __ Employer __ Insurer __ Dependent __ Health Care Provider __ LWC __ 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 $ ________

LWC-WC-1008
REV. 4/14

COMPLETE BOTH PAGES

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 LWC-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