Louisiana Workforce Commission

John Bel Edwards
Governor

Ava Dejoie
Secretary

OFFICE OF WORKERS' COMPENSATION ADMINISTRATION

SIF CLAIM NO.
CARRIER'S CLAIM NO.
DATE OF ACCIDENT

EMPLOYEE:	CARRIER/SELF-INS.
EMPLOYER:	

DISABILITY BENEFITS PROVIDED TO INJURED EMPLOYEE

	WEEKL	FROM - TO THIS SUBMISSION	TOTAL WEEKS THIS SUBMISSION	AMOUNT
TTD				
PTD				
SEB				
DEATH				
SETTLEMENT				
TOTAL INDEMNITY PAID THIS SUBMISSION				$
TOTAL MEDICAL BENEFITS PAID THIS SUBMISSION				$

MEDICAL REIMBURSEMENT REQUEST

THE FOLLOWING MUST BE PROVIDED:

A. AN ITEMIZED LIST OF ALL MEDICAL EXPENSES IN CHRONOLOGICAL ORDER.

B. COPIES OF ALL MEDICAL BILLS ATTACHED AND NUMBERED TO CORRESPOND WITH ITEMIZED LIST. MEDICAL BILLS SHOULD BE IN CHRONOLOGICAL ORDER.

C. COPIES OF DRAFTS OR COMPUTER PRINTOUT TO DOCUMENT PAYMENT.

D. MEDICAL REPORTS TO JUSTIFY PRESENT DISABILITY.

SETTLEMENTS:

A. SIGNED PETITION, JUDGMENT, RECEIPT AND RELEASE, ORDER FROM OWCA, AND A COPY OF THE CHECK OR COMPUTER PRINTOUT.

B. SETTLEMENTS FOR AN ACCIDENT OCCURRING ON OR AFTER OCTOBER 1, 1995 AND APPROVED BY THE LA. W. C. SIB, THE EMPLOYER/ SELF-INSURED OR INSURER MUST OBTAIN PRIOR WRITTEN APPROVAL FROM THE BOARD OF ANY LUMP SUM OR COMPROMISE SETTLEMENTS.

QUESTIONS:

HAS ANY SUBROGATION ACTION BEEN TAKEN OR DO YOU INTEND TO TAKE ANY ACTION TO RECOVER ALL OR PART OF THE COMPENSATION PAID TO THE EMPLOYEE? IF YES EXPLAIN_____YES _____NO

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I HEREBY CERTIFY THAT AS OF THIS DATE, THE AFOREMENTIONED INFORMATION IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

INSURANCE CARRIER _____ **SIGNATURE** _____ **TITLE**

PHONE # _____ **DATE** _____

EMAIL _____