

LOUISIANA WORKFORCE COMMISSION  
 OFFICE OF WORKERS' COMPENSATION ADMINISTRATION  
 POST OFFICE BOX 94040  
 BATON ROUGE, LA 70804-9094  
 (800) 201-2494

**SPECIAL  
 REIMBURSEMENT  
 CONSIDERATION  
 APPEAL**

**INSTRUCTIONS:** Please provide the following information and return Parts 1 and 2 intact with the required medical records to the address shown below. Send Part 3 to the Workers' Compensation insurance carrier. Retain the last copy for your files. It should be understood that an appeal is not a guarantee of additional reimbursement.

DATE	WORKERS' COMPENSATION CARRIER NAME AND ADDRESS
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**HOSPITAL INFORMATION**

HOSPITAL NAME			
ADDRESS		CITY, STATE, ZIP	
CONTACT PERSON	TITLE	TELEPHONE	EXT

**PATIENT INFORMATION**

PATIENT NAME		SOCIAL SECURITY NUMBER	
EMPLOYER NAME AND ADDRESS		DATES OF SERVICE	
PATIENT ADDRESS		CITY, STATE, ZIP	
DIAGNOSIS AND SURGICAL PROCEDURES			
WAS ADMISSION PRE-CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, HAS OFFICE OF WORKERS' COMPENSATION BEEN NOTIFIED OF THE ADMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**MEDICAL INFORMATION**

The following information <b>must</b> be submitted with and appeal for special reimbursement consideration.	
<ul style="list-style-type: none"> <li>Entire medical record</li> <li>Itemization of charges</li> </ul>	<ul style="list-style-type: none"> <li>All supporting information which could substantiate percentage of charge reimbursement.</li> </ul>

STATE OFFICE OF WORKERS' COMPENSATION USE ONLY		
SPECIAL CASE CONSIDERATION	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
NAME	TITLE	REIMBURSEMENT RATE
REASON		

**SEND THIS  
 FORM TO :**



Louisiana Workforce Commission  
 Office of Workers' Compensation Administration  
 Medical Services Section  
 Post Office Box 94040  
 Baton Rouge, LA 70804-9040