EMPLOYER/PAYOR MAIL TO:

OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040

1. Employee Social Security No. _____ -_____-_____

2. Payor Claim No.:_____

3. Date of Injury/Illness _____

4. Date of Notice: _____

NOTICE OF PAYMENT, MODIFICATION, SUSPENSION, TERMINATION OR CONTROVERSION OF COMPENSATION OR MEDICAL BENEFITS

5. Purpose of Form (check one):

Initial Payment ____ Modification ____ Suspension ____ Termination____ Controversion ____

6. (a) Employee Name: _____
Address: _____
Telephone: _____

(b) Employee Representative Name (if known)_____
Address: _____
_____
Telephone: _____
Facsimile: _____

(c) Employer Name: _____
Address: _____
_____
Telephone: _____
Facsimile: _____

7. Effective Date of Initial Payment, Modification, Suspension, Termination or Controversion:_____/_____/20_____

8. Description of Injury/Occupational Disease: _____
_____

9. Average Weekly Wage: $_____

10. **Payment/Modification** (check one): Initial Payment ____ Modification____

Indemnity Benefits are to be paid as follows:

A. Permanent Total Disability (PTD)___ Temporary Total Disability (TTD)___ (check one) benefits at the rate of $_____ per week;

B. Supplemental Earnings Benefits (SEB) paid at the rate of $_____per _____ based on a wage earning capacity of $_____; **OR**

SEB paid at the rate of$ _____ per _____ dependent on wages as reflected in LWC-WC-1020's to be submitted by employee each month;

C. Reduced PTD___ TTD____ SEB_____ (check one) at the rate of $_____ due to employee's receipt of (check applicable item):
_____ Social Security Benefits at the rate of $_____ per _____;
_____ Other Workers' Compensation Benefits at the rate of $_____ per _____'
_____ Employer Funded Disability Benefits at the rate of $_____ per _____;
_____ Unemployment Insurance Benefits
_____ Third Party Recovery in the amount of $_____
_____ 50% reduction of compensation based on Employee's refusal to cooperate with Vocational Rehabilitation
_____ Reduction due to child support order
_____ Other (Describe): _____

D. Permanent Partial Disability (PPD) Benefits of $_____ per week payable for _____ weeks.
E. Death Benefits have begun in the amount of $ _____ per week, representing _____% of AWW.

Employee Name _____

Date of injury/illness_____

11. **Suspension/Termination**

Indemnity and/or Medical Benefits have been suspended/terminated due to:
_____ Employee's refusal to submit to a medical examination;
_____ Employee's refusal to execute a Choice of Physician form;
_____ Fraud
_____ Dispute over Compensability (Describe): _____
_____
_____
_____
_____ Employee's refusal to return the form LWC-WC-1025 or LWC-WC-1020;
_____ Released to return to work full duty;
_____ Employee able to earn 90% of pre-accident average weekly wage; or
_____ Other (Describe): _____
_____
_____
_____

12. **Controversion**

Employee's rights to Indemnity and/or Medical Benefits are disputed and have been denied because Employer/Payor disputes:
_____ Compensable Work Accident;
_____ Compensable Injury;
_____ Employment Relationship;
_____ Causation;
_____ Disability;
_____ Fraud;
_____ Jurisdiction; or
_____ Other (Describe): _____
_____
_____
_____

13. Notice Submitted By:

Signature of Preparer: _____
Printed name: _____
Position/Affiliation: _____
Telephone:_____
Facsimile: _____
Address: _____
_____

14. Please provide the following information:

Payor/Self Insured Employer Name: _____
Telephone _____
Facsimile: _____
Address: _____
_____

NOTICE OF DISAGREEMENT
(to be completed by Employee/Employee Representative)

MAIL TO:

The preparer for Employer/Payor
at the address listed in Section 13
of the LWC-WC-1002.

Employee Social Security No.: _____-____-_____

Payor Claim No. (if known): _____

Date of Injury/Illness: _____

Date of Notice of Disagreement: _____

BASIS OF DISAGREEMENT

1. Average Weekly Wage is incorrect. The correct AWW amount is $_____.

2. The type of workers' compensation indemnity benefits is incorrect. The correct type is PTD/TTD/SEB/PPD (circle one).

3. The amount/rate of workers' compensation indemnity benefits is incorrect. The correct amount is $_____ per _____.

4. The basis for Employer/Payor's suspension/termination/controversion of benefits is incorrect because (describe):
_____
_____
_____

5. Other (describe): _____
_____
_____

6. Notice Submitted By:

Employee Name: _____
Telephone _____
Address: _____
_____

Employee Representative _____
La. Bar Roll No. _____
Address: _____
_____
Telephone: _____
Facsimile: _____

Signature _____
Printed name: _____