Human Resource Management

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Authorization for Medical Treatment
under the Louisiana Workers' Compensation Act

Name of Employee: _____ **Date of Injury:** _____

Employee's Department: _____ **Campus: LSU Agricultural Center**

Date of Injury: _____ **Date of this Referral:** _____

This employee has been injured on the job and you are authorized to provide necessary medical services. Please send all medical bills, medical notes and records and work status information related to this workers' compensation claim to Sedgwick directly. All bills should be submitted on a HCFA 1500 billing form. Attach Sedgwick claim number to all documents whenever possible:

Sedgwick Claims Management Services, Inc.
Claim# _____(if available at time of visit)
P.O. Box 14775
Lexington, KY 40512
Or
Fax: 859.225.2000

(The doctor is requested to give the employee a note when he/she is released to return to work.)

Disposition of Employee:

Referred to another doctor: _____
Dr's Name & Address

Treated and released to return to work: _____
Date

Sent home or sent to the hospital: _____

Estimated length of time away from the job: _____

FIRST AID TREATMENT ONLY: _____

Return to Health Service Facility: _____**Yes;** _____**No**

If yes, Date of return: _____

_____
Health Service Provider