MAIL TO:
OFFICE OF WORKER'S COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70807-9040
(225) 342-7565, TOLL FREE (800) 201-3457

SOCIAL SECURITY NUMBER _____ - _____ - _____

DATE OF INJURY/ILLNESS _____ - _____ - _____

**STOP PAYMENT FORM**

This form is sent by the Employer/Insurer to the injured worker and the OWC within 30 days of the closure of a case.
An **AMENDED COPY** is required if the case re-opens or additional costs are incurred.

1. 2. _____ - _____ - _____ _____ _____ _____
(Employee) (Date of Birth) Date of this Notice

3. 4. _____ - _____ - _____ _____ _____ _____
Part(s) of Body Injured Date Compensation Paid Through

5. Purpose of Form: (check one)
❑ Payment stopped-Employee working at equal or greater wage ❑ Payment stopped-Maximum period for paying SEB has expired
❑ Payment stopped-Employee able to work at same or greater wage ❑ Payment stopped-3rd Party recovery without notice
❑ Payment stopped-Lump sum/Compromise settlement approved ❑ Amend or correct prior 1003
❑ Other _____

6. Length of Disability _____ weeks _____ days.

7. Give **ICD - 9** Diagnostic code(s) _____ .

8. Give **CPT** Procedure code(s) _____ .

9. COSTS INCURRED FOR THIS CASE:

A. Indemnity Benefits
1. Temporary total $ _____
2. Supplemental earnings _____
3. Permanent partial _____
4. Permanent total _____
5. Death benefits _____
6. Other benefits _____

TOTAL INDEMNITY _____
(Add A. items 1-6)

D. Rehabilitation Expenses
1. Medical rehabilitation $ _____
2. Vocational rehabilitation _____
3. Labor Market Survey _____
4. _____
5. Other _____

TOTAL REHABILITATION _____
(Add D. Items 1-5)

B. TOTAL SETTLEMENT AMOUNT $ _____

C. Medical Expenses
1. Hospital $ _____
2. Physician _____
3. Diagnostic Tests/ _____
4. Prescription _____
5. Transportation _____
6. Independent Medical _____
7. Occupational/Physical Therapy _____
8. _____

E. TOTAL FUNERAL $ _____

F. Legal Expenses
1. Attorney Fees $ _____
2. Court Costs _____
3. Deposition Costs _____
4. Investigation _____
5. Penalties and Interest _____
6. Administrative/Other _____

TOTAL MEDICAL _____
(Add C. Items 1-8)

TOTAL LEGAL EXPENSES _____
(Add E. Items 1-5)

G. 3RD PARTY RECOVERIES FOR COSTS $ _____
(NOT INCLUDED ABOVE)

H. TOTAL WORKERS' COMPENSATION COSTS $ _____
(Add A - G)

I . BALANCE OF UNUSED $ _____

Submitted by:
Preparer's Name: _____

Employer/Insurer: _____

Address: _____

_____

Phone: ( ) _____

Empoyer/Insurer NCCI Number: _____

LDOL-WC-1003
REV. 1/98