MAIL TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9094
(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 workers and the OWCA 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. _____
(Employee) (Date of Birth)

2. _____-_____-_____
Date of this Notice

3. _____
Part(s) of Body Injured

4. _____-_____-_____
Date Compensation Paid Through

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

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 BENEFITS (Add A. Items 1-6) $ $0.00

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

TOTAL REHABILITATION EXPENSES (Add D. Items 1-5) $ $0.00

B. TOTAL SETTLEMENT AMOUNT $_____

E. TOTAL FUNERAL EXPENSES $_____

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

TOTAL MEDICAL EXPENSES (Add C. Items 1-8) $ 0.00

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

TOTAL LEGAL EXPENSES (Add F. Items 1-6) $ 0.00

G. 3RD PARTY RECOVERY FOR COSTS (Not Included Above) $_____

H. TOTAL WORKERS' COMPENSATION COSTS (Add A-G) $ 0.00

I. BALANCE OF UNUSED RESERVES $_____

Submitted by:

Preparer's Name: _____

Employer/Insurer: _____

Address: _____

_____

Phone: ( ) _____

Employer/Insurer NCCI Number:_____

Employee Name: _____

Employer: _____

Address: _____

_____

Phone: ( ) _____

LDOL-WC-1003
REV. 10/98